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Notice of Meeting

Health and Wellbeing Board

Thursday 30 March 2017 at 3.00pm

in Council Chamber Council Offices
Market Street Newbury

Date of despatch of Agenda: Tuesday 21 March 2017

For further information about this Agenda, or to inspect any background documents referred to in Part I reports, please contact Jo Reeves / Jessica Bailiss on (01635) 519486/503124
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Further information and Minutes are also available on the Council's website at www.westberks.gov.uk

West Berkshire COUNCIL

To: Heather Bowman (Executive Director, Housing & Communities (Sovereign)), Garry Poulson (Volunteer Centre West Berkshire), Paul Jones (Group Manager (RBFRS)), Dr Bal Bahia (Newbury and District CCG), Dr Barbara Barrie (North and West Reading CCG), Dr Lise Llewellyn (Public Health), Rachael Wardell (WBC - Corporate Director: Communities), Cathy Winfield (Berkshire West CCGs), Councillor Lynne Doherty (Executive Portfolio: Children's Services), Councillor Graham Jones (Executive Portfolio: Health and Wellbeing), Councillor Mollie Lock (Shadow Executive Portfolio: Education and Young People, Adult Social Care), Andrew Sharp (Healthwatch), Councillor Roger Croft (Executive Portfolio: Leader of Council, Strategy & Performance, Finance), Councillor Rick Jones (Executive Porfolio: Adult Social Care), Councillor Marcus Franks (Executive Portfolio: Community Resilience & Partnerships) and Richard Benyon MP

Agenda

Part I

Page No.

1 **Apologies for Absence**
To receive apologies for inability to attend the meeting (if any).

2 **Minutes** 7 - 16
To approve as a correct record the Minutes of the meeting of the Board held on 24 November 2016. .

3 **Health and Wellbeing Board Forward Plan** 17 - 20
An opportunity for Board Members to suggest items to go on to the Forward Plan.

4 **Actions arising from previous meetings**
To consider outstanding actions from previous meetings.
(There are no outstanding actions remaining.)

5 **Declarations of Interest**
To remind Members of the need to record the existence and nature of any personal, disclosable pecuniary or other registrable interests in items on the agenda, in accordance with the Members' Code of Conduct.

6 **Public Questions**

Members of the Health and Wellbeing Board to answer questions submitted by members of the public in accordance with the Executive Procedure Rules contained in the Council's Constitution.

a **Question submitted by Ms Pam Hayden:**

"What accommodation and support is available for those who are homeless or at risk of homelessness with severe mental health issues?"

b **Question submitted by Ms Pam Hayden:**

"What mechanisms are available to improve communication between homeless people with mental health issues and their support workers?"

c **Question submitted by Ms Pam Hayden:**

"What new funding is the Government making available to support people with mental health issues?"

d **Question submitted by Mrs Martha Vickers:**

"I understand that a community resilience officer is to be appointed to work with volunteers, the community sector and local businesses in support of the Health and Wellbeing Strategy; can you tell me how this appointment will be promoted in our communities?

e **Question submitted by Mrs Martha Vickers:**

"Can you tell me about the intended audience of, promotion of and cost of Mental Health First Aid courses?

f **Question submitted by Mrs Martha Vickers:**

"Can the Board tell me how incidents of Asthma in Newbury compare with other towns in Berkshire?"

7 **Petitions**

Councillors or Members of the public may present any petition which they have received. These will normally be referred to the appropriate Committee without discussion.

Items for discussion

8 **Mental Health Focus (Richard Benyon MP, Alison Foster, Darrell Gale, Bev Searle, Jason Jongali, Rachel Johnson)** 21 - 96

For the Board's guest, Richard Benyon MP, to address the Board on the subject of mental health and for the Board to respond by outlining some of the activity which is ongoing at Berkshire-wide, Berkshire West and West Berkshire levels.

Berkshire-wide activity:

- Brighter Berkshire Campaign
- Berkshire Suicide Prevention Strategy

Berkshire West activity:

- Berkshire West Mental Health Strategy

West Berkshire activity:

- Mental Health Collaborative Action Plan
- West Berkshire Suicide Prevention Action Plan

9 **Better Care Fund 2017/19 (Tandra Forster/ Shairoz Claridge)** 97 - 104

To inform the Health and Wellbeing Board about draft plans for the Better Care Fund.

Systems Resilience

10 **Feedback from the Hot Focus Session: Systems Resilience Dashboard (Jo Reeves)** 105 - 110

To inform the Health and Wellbeing Board of the outcome of the Hot Focus Session held on 23 February 2017 to refresh the Systems Resilience Dashboard and to seek approval of the new approach.

Programme Management

11 **Report from the Health and Wellbeing Steering Group (Jo Reeves)** 111 - 116

To inform members of the Health and Wellbeing Board of the latest progress achieved by its sub-groups in delivering the Health and Wellbeing Strategy and to highlight any emerging issues which requires the Board members' attention.

a **Review of Community Conversations (Susan Powell)** 117 - 134
To provide an update on progress against the Board's strategic focus to increase the number of community conversations through which local issues are identified and addressed.

b **Update on Alcohol Reduction Partnership Activities (Debi Joyce)** 135 - 156
For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's strategic focus to reduce alcohol related harm across the district for all age groups.

Items for Information

12 **The Buckinghamshire, Oxfordshire and Berkshire West (BOB) NHS Sustainability and Transformation Plan (STP) (Cathy Winfield)** 157 - 166
For the Board to receive the final Buckinghamshire, Oxfordshire and Berkshire West (BOB) NHS Sustainability and Transformation Plan (STP) Submission.

13 **Berkshire West Clinical Commissioning Groups (CCGs) Operational Plan (Cathy Winfield)** 167 - 214
To receive information on the Berkshire West Clinical Commissioning Groups (CCGs) Operational Plan 2017-19.

14 **Members' Questions**
Members of the Health and Wellbeing Board to answer questions submitted by Councillors in accordance with the Executive Procedure Rules contained in the Council's Constitution. *(note: there were no questions submitted relating to topics not on the agenda)*

15 **Future meeting dates**
Thursday 25 May 2017, 9.30am at West Berkshire Community Hospital

Andy Day
Head of Strategic Support

If you require this information in a different format or translation, please contact Moira Fraser on telephone (01635) 519045.

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DRAFT

Note: These Minutes will remain DRAFT until approved at the next meeting of the Committee

HEALTH AND WELLBEING BOARD

MINUTES OF THE MEETING HELD ON THURSDAY, 24 NOVEMBER 2016

Present: Dr Bal Bahia (Newbury and District CCG), Dr Barbara Barrie (North and West Reading CCG), Dr Lise Llewellyn (Public Health), Rachael Wardell (WBC - Community Services), Cathy Winfield (Berkshire West CCGs), Councillor Lynne Doherty (Executive Portfolio: Children's Services), Councillor Graham Jones (Executive Portfolio: Health and Wellbeing), Councillor Rick Jones (Executive Porfolio: Adult Social Care), Garry Poulson (Volunteer Centre West Berkshire), Paul Jones (Group Manager (RBFRS)) and Jim Weems (Thames Valley Police)

Also Present: Lesley Wyman (WBC - Public Health & Wellbeing), Tandra Forster (WBC - Adult Social Care), Shairoz Claridge (Newbury and District CCG) and Jo Reeves (Policy Officer)

Apologies for inability to attend the meeting: Councillor Mollie Lock and Andrew Sharp

PART I

15 Educational Attainment and Health Outcomes of Children from Vulnerable Families

Before the commencement of the meeting, Councillor Graham Jones asked to put on record the Board's thanks to Leila Fergusson for her service to the Board since it's establishment in 2013 and welcomed Garry Poulson as the new voluntary sector representative.

The Board considered a report (Agenda Item 2) to respond to the Board's request to receive information regarding the educational attainment and health outcomes of children from vulnerable families. The report had been written jointly between the Public Health and Education departments.

Maxine Slade began introducing the report by explaining that the definition of a vulnerable family came from the Department for Education and included children entitled to Free School Meals (FSM) or children/ young adults in care. This definition was problematic because all children in Key Stage 1 were now entitled to a free school meal, therefore parents were encourage to still apply so they and the school could benefit from Pupil Premium funding. Maxine Slade also explained that there was a limitation with how progress in educational attainment was defined; pupils who improved from a 'D' grade to 'C' grade were recorded as making progress but a pupil who improved from an 'F' grade to a 'D' grade was not, despite that potentially being a significant achievement for that pupil.

Dr Barbara Barrie joined the meeting at 9.38am)

Maxine Slade explained that in 2016, all children entitled to FSM had improved educational attainment, however children not entitled to FSM made more improvement so the attainment gap widened, likewise with children with Special Educational Needs and Disability (SEND). Referring to the report, Maxine Slade summarised the activities undertaken by the Education department and schools to address the educational attainment gap.

Councillor Lynne Doherty commended the amount of work undertaken to encourage the take up of Pupil Premium funding. Regarding the recommendations in the report, Councillor Doherty expressed the view that these could be more specific about how the Board could help to drive improvement. She also expressed the view that there might be some key messages that the Board could help transmit, such as the importance of breakfast to a child's health and attainment at school. Councillor Doherty continued that there might be more work around the transition from early years that to be done. Maxine Slade responded that staffing levels had reduced so this was more difficult but vulnerable two year-olds were tracked through early years and their information was given to the accepting school.

Councillor Doherty asked how West Berkshire's performance compared with national averages. Ian Pearson advised that the South East usually performed better than the national average and West Berkshire was usually in the higher part of the South East overall but there was work to do and there was no complacency.

Councillor Doherty suggested that the Children's Delivery Group be consulted to develop clear recommendations for the Board and report back at a later date, including the best ways to spend Pupil Premium Grant. Ian Pearson clarified that Pupil Premium and FSM were just proxy measures and there was another cohort, families just about managing, that might need just as much support as Pupil Premium children but were not eligible for the funding. Maxine Slade added that officers have known about that cohort of children for some time and encourage schools to include those children in targeted support groups for Pupil Premium children.

Dr Lise Llewellyn noted that reducing the educational attainment gap was a difficult problem nationally and a particularly difficult problem to address in area of relative affluence. She enquired whether health visitors could do more to identify children from vulnerable families at their two year-old checks or if wider activities such as breakfast clubs could be pursued. Maxine Slade responded that a lot of work had been done regarding health visiting. Ian Pearson, on breakfast clubs, stated that many schools have offered these but changes in the way schools were funded by the government had lead to breakfast club closures.

Councillor Rick Jones agreed with Councillor Doherty that the report's recommendations could be more focussed and explain what the objectives were, where on the path West Berkshire was and how the Board fit in.

Dr Bal Bahia noted that there was still work to be done to identify the barrier for increased take up of free nursery places and also raised that there were other health issues, such as low physical activity and low self esteem, particularly for adolescent girls, which played a factor in educational attainment. Maxine Slade agreed with this point and explained that seven of the ten West Berkshire secondary schools were academies so the School Improvement Team did not have the same footprint.

RESOLVED that the report be noted.

16 Minutes

The Minutes of the meeting held on 7 July 2016 were approved as a true and correct record and signed by the Chairman.

17 Health and Wellbeing Board Forward Plan

The Health and Wellbeing Board noted the forward plan. The following items were added to the meeting to be held in March 2017:

- Director of Public Health's Annual Report

- Clinical Commissioning Groups (CCG) Two-Year Operational Plan
- Final Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (STP) Submission

Alison Foster commented that March 2017 was a long time away with only private meetings and asked what opportunity the public would have to comment on the STP before it was finalised. Councillor Graham Jones advised that the Council's Overview and Scrutiny Management Commission would be scrutinising the plan at its meeting on 6 December 2016. Cathy Winfield added that the CCG held public meetings. Councillor Jones also advised that if it was necessary to hold a public meeting before March 2017 it could be arranged and there was a discussion on the STP later on the agenda for the meeting. Cathy Winfield explained that Healthwatch were represented within the STP's governance structure.

18 Actions arising from previous meeting(s)

The Health and Wellbeing Board noted actions arising from the previous meeting.

19 Declarations of Interest

Dr Bal Bahia and Dr Barbara Barrie declared an interest in all matters pertaining to Primary Care, by virtue of the fact that they were General Practitioners, but reported that as their interest was personal and not a disclosable pecuniary or other registrable interest, they determined to remain to take part in the debate and vote on the matters where appropriate.

Andrew Sharp declared an interest in any items that might refer to South Central Ambulance Service due to the fact that he was the Chair of Trustees of the West Berks Rapid Response Cars (WBRRC), a local charity that supplied blue light cars for ambulance drivers to use in their spare time to help SCAS respond with 999 calls in West Berkshire, and reported that, as his interest was personal and not a disclosable pecuniary or other registrable interest, he determined to remain to take part in the debate and vote on the matters where appropriate.

20 Public Questions

There were no public questions submitted.

21 Petitions

There were no petitions presented to the Board.

22 Health and Social Care Dashboard

The Board considered a report (Agenda Item 9) concerning the health and social care dashboard.

Tandra Forster began by providing an overview of the status of the Better Care Fund (BCF). The Policy Guidance would be published by the end of November 2016 and would be finalised by the end of March 2017. Some increase in funding was anticipated across the two year BCF, with a 1.79% increase in 2017/18 and 1.9% increase in 2018/19. The number of national conditions had been reduced and would be focused on protecting social care; out of hospital services; and joint plans. More information would be known in the coming weeks.

ASC1 – Proportion of older people (65+) who were still at home 91 days after discharge from hospital to reablement/rehabilitation service: Tandra Forster advised that the target for 2016/17 was 88%, not 92% and so performance was exceeding the target and should be green.

AS2 – Average number of Delayed Transfers of Care per 100,000 population: performance against this target was correctly showing as red against target but was improving. The reason for the delay was down to difficulties in acquiring home care; this accounted for 70% of delays and recruitment issues was the main factor. Providers were also withdrawing for the market. Delays would continue to be addressed in the following year's BCF.

Dr Lise Llewellyn asked how West Berkshire was performing in comparison to Wokingham who had set up their own arms-length care provider. Tandra Forster explained that their Wokingham Integrated Social Care and Health (WISH) Team was equivalent to West Berkshire's Joint Care Pathway (JCP) and they were able to pay more for care. Dr Llewellyn asked if their capacity was any better; Councillor Rick Jones commented that if they were able to pay more they would be likely to be able to acquire more care. Cathy Winfield expressed the view that the difficulty in acquiring care was a recurring theme and it might be worth considering a system-wide solution at one of the Board's Hot Focus Sessions. Tandra Forster commented that Delayed Transfers of Care was a subject also being considered at the Council's OSMC meeting on 6 December 2016 and the Board could consider their recommendations at the Hot Focus Session.

ASC2 – Number of assessments completed in the last 12 months leading to a provision of a Long term service: West Berkshire was performing better than the national average for assessments.

Rachael Wardell informed the Board that there was an improving picture across the children's Social Care Indicators due to the hard work of frontline teams and West Berkshire was bucking the national trend on a number of measures.

CSC2 – the number of child protection plans per 100,000 population: Not only was the number of children on CP plans reducing but the time spent on a plan was reducing. Attention had now turned to monitoring those children who then returned to a CP plan, but no worrying trends had been identified and Rachael Wardell concluded that West Berkshire had become more effective at prevention and this was improving family life.

CSC3 – The number of Section 47 enquiries per 10,000 population: Performance against this indicator was more troubling. A Section 47 Enquiry was a statutory social work responsibility and was an action not taken lightly as it could be a massive interference into a family which might cause harm. The new Multi Agency Safeguarding Hub (MASH) would mean there was a better aggregation of information. Social work teams did not view these indicators as having targets and they sought to ensure that they were doing the right thing by the child

CSC7 – Percentage of LAC with Health Assessments completed on time: A significant amount of work had been put in to turn around performance on this indicator which continued to be very strong. There might be other indicators such as dental health checks which might now need to be scrutinised by the Board.

Paul Jones asked what peer assessment had been undertaken in Children's Services. Rachael Wardell responded that West Berkshire Council had been quite heavily peer assessed in recent years including Department for Education (DfE) interventions following the Ofsted inspection in March 2015. The six month review would be happening in early December. The new MASH also helped to make safeguarding decisions as there would be input from Thames Valley Police and health colleagues. Cathy Winfield asked where Section 47 referrals came from. Rachael Wardell responded that referrals came from members of the public and from professionals in other organisations – a high number from schools. Social workers made the decision to conduct a Section 47 enquiry if there was evidence to suggest the child was at risk of significant harm. In many cases

on receipt of a referral there would be services put in place which could help the child or family but the circumstances would fall short of a Section 47 enquiry. In some circumstances the person making the referral might require additional training or signposting.

AS1 – 4-hour A&E target: Shairoz Claridge explained that while performance against these indicators was showing as amber and red, more recent data was showing that it would be unlikely that the Royal Berkshire Hospital (RBH) would meet the 95% target as winter was approaching. RBH were performing the second best in the area but still not able to reach the target. The local System Resilience Group had been transformed into Local A&E Delivery Boards to focus solely on Urgent & Emergency Care, and attendance at executive level by member organisations was expected. This was a requirement from NHS England of all CCGs. Five improvement areas were identified and a new 999 response programme called 'Nature of the Call' was identifying key words and phrases to prioritise emergency responses.

AS5 – Ambulance Clinical Quality: Performance against this indicator was red in July and the CCGs had agreed an action plan with SCAS which was anticipated to improve standards by February 2017.

AS6 – A+E attendances and AS7 – Number of non elective admissions: These levels were both increasing, despite the CCGs being in the top 10 nationally.

CS2 – Mental Health DTOCs: Tandra Forster advised that this was the first time that mental health DTOCs were being reported as there was an increasing focus on mental health so no comparison could yet be made.

Rachael Wardell advised that she had seen un-validated data against indicators up to September 2016 and the dashboard was reporting data as old as July 2016. She suggested that the reporting cycle be amended to enable more recent data to be presented to the Board. Councillor Lynne Doherty suggested that the dashboard was presented with a caveat to state that performance was within a variance. Councillor Graham Jones suggested that this information be something the Steering Group look into.

Alison Foster raised a query regarding patient flows towards hospitals. Shairoz Claridge explained that 60-70% of patients went to the Royal Berkshire Hospital in Reading and of the rest, the majority of patients went to the North Hampshire Hospital in Basingstoke with about 8-10% attending the Great Western Hospital in Swindon. Tandra Forster explained that there had historically been an issue with the level of DTOCs from North Hants. Alison Foster considered the conversion rate from A&E attendances to non elective admissions and asked if there was a risk that people who needed to be admitted were being sent away. Shairoz Claridge admitted that there was always a risk but a lot of work had gone into ensuring patients received the right clinical support before attending A&E. Cathy Winfield added that the CCGs wanted a high conversion rate because it offered reassurance that people were attending A&E for the right reasons. Short stays were sought as they would evidence patients being treated efficiently.

RESOLVED that the health and social care dashboard be noted.

23 Health and Wellbeing Strategy

The Board considered a report (Agenda Item 10) concerning the Health and Wellbeing Strategy refresh. The first Health and Wellbeing Strategy (HWS) was developed in 2013 and an updated version was published in early 2015. Following the LGA Peer Challenge in March 2016, it became apparent that the strategy needed to be refreshed for a number of reasons:

- To decrease the number of priorities to a more realistic number,
- To set out a clearer vision of the Health and Wellbeing Board,
- To demonstrate how the strategic aims and objectives will be achieved,
- To demonstrate the governance of the Health and Wellbeing Board,
- To be clearer about how the Board operates as systems leaders,
- To ensure that the Health and Wellbeing Strategy drives the commissioning of all partners,
- To integrate the work of the Building Community Together partnership,
- To fully integrate work around the wider determinants of health into the
- strategy.

Alison Foster enquired how alcohol was chosen as an area of focus. Lesley Wyman advised that the subject had emerged through a number of meetings of the Board and with wider stakeholders as something a range of agencies could drive improvement against if they worked in an effective way. Rachael Wardell commented that alcohol was a factor involved in a significant proportion of safeguarding issues.

Cathy Winfield commented that the presentation of the strategy was good and thanked Lesley Wyman for producing it.

RESOLVED that the Health and Wellbeing Strategy be approved.

24 Health and Wellbeing Board Governance

The Board considered a report (Agenda Item 11) concerning the Health and Wellbeing Board governance, the purpose of which was to enable the Health and Wellbeing Board to drive improvement against the Health and Wellbeing Strategy and fulfil its intended role as a system leader. This report defined how its governance would be amended to enable it to be more effective.

It was proposed that the membership of the Board should include system leaders from other local public sector organisations such as Thames Valley Police, Royal Berkshire Fire and Rescue Service, Housing Associations and the Portfolio Holder for Community Resilience and Partnerships.

It was noted that there had been a number of changes in how the Health and Wellbeing Board worked over the last few months and the same process would be applied to the Steering Group. The aim was to streamline the process to enable the Board and its sub-groups to work more effectively.

Rachael Wardell offered her support for the report and expressed a warm welcome to Paul Jones (Royal Berkshire Fire and Rescue Service) and Jim Weems (Thames Valley Police) who had joined the Board.

Referring to the governance diagram, Alison Foster note a number of lines of relationship and accountability, and queried where the Board fit in, particularly with the STP governance. Nick Carter advised that the governance was driven to an extent by some internal work he had been completing to clarify how resource was allocated to the Board through a multi-agency team and a Senior Management Review. A further paper would be produced to outline this in more detail as he thought some of the linkages, particularly to the role of the local economy was missing.

Rachel Wardell expressed the view that it would be useful if the governance diagram distinguished between a line of accountability and a relationship. Dr Bal Bahia commented that the diagram at present demonstrated the landscape rather than the governance.

Dr Lise Llewellyn acknowledged that there was already work ongoing to improve relationships between health, TVP and RBFRS, noting the successful Fire Fit programme which had been taken up in schools.

RESOLVED that the Health and Wellbeing Board Governance be approved.

25 Feedback on the Health and Wellbeing Strategy Hot Focus: Alcohol

The Board considered a report (Agenda Item 12) to feedback on the Alcohol Hot Focus session and suggested further actions.

The Health and Wellbeing Strategy Board agreed that within the Health and Wellbeing Strategy two key priorities would be identified that would be the Board's focus for the coming year, from October 2016 to October 2017. One of these was to reduce alcohol related harm in West Berkshire and it was further agreed that a multiagency task and finish group would be set up to take this work forward.

In order to help the Health and Wellbeing Board and other key community stakeholders gain a greater understanding of current services available to reduce alcohol related harm in West Berkshire an Alcohol Hot Focus session was run on 27 October 2016.

Positive comments were fed back at the end of the session with partners stating that it had been helpful in understanding what services were available and who did what locally. There was also a great deal of positivity about the opportunity for partners to work more closely together particularly in setting up a task and finish group and to conduct a mapping exercise.

This group, to be named the Alcohol Harm Reduction Partnership, held its first meeting on 15 November. It was well attended and the Partnership was in the process of agreeing its terms of reference. They would then be completing a needs assessment.

Councillor Graham Jones expressed his thanks to the team that organised the Hot Focus Session which helped to outline the multi-agency approach already being taken. He found that the lived experience of one of the speakers who was a recovering alcoholic was particularly memorable.

Dr Llewellyn noted that alcohol related harm was one of the prevention issues in the forthcoming STP, including how different sectors of the health system responded to alcohol.

Alison Foster asked how the Partnership would measure its impact. Lesley Wyman advised that a number of indicators could be used such as alcohol-related admissions to A&E or alcohol-related disturbances in the night time economy. Each organisation came to the table with its own key performance indicators and the Partnership would determine which would be used as measures of success.

Councillor Doherty thanked officers for the paper and the Hot Focus Session, noting the role of alcohol in around 95% of Child Protection Plans.

RESOLVED that the report be noted.

26 Sustainability and Transformation Plan Update

Cathy Winfield gave a presentation to the Board (Agenda Item 13) concerning an update on the Sustainability and Transformation Plan (STP) submission. She advised that she had made some updates to the version included in the agenda and this would be published on the website following the meeting.

The STP would encompass working with a number of different statutory organisations which would retain their autonomy, but there were opportunities to streamline back office functions. For example the CCGs, Royal Berkshire Hospital and Berkshire Hospitals

Foundation Trust might share some functions or even collocate as part of the One Public Estate programme to deliver value for money.

The STP had five key ambitions: prevent ill health; improve access to urgent care, improve hospital services, improve mental health services and to co-commission specialist services. To achieve these ambitions there were two enabling workstreams: workforce and digital solutions. New ways to improve recruitment and retention were being pursued, including rotational opportunities across organisations to keep work varied and it was planned to reduce agency spend. More digital solutions for self care and remote appointments were being investigated.

Initial assessments suggested if nothing was done differently, rising costs, inflation and demand on the NHS would lead to a gap of £479m by the end of 2020/21 so while there was not going to be a cut to funding, there needed to be transformation in the ways services were delivered. Since then CCGs had undertaken more detailed planning and reviewed the initial assumptions. Once CCG Operating Plans for 2017-2019 were finalised the STP financial position will be refreshed in January 2017 and a final version of the STP would be published.

The governance arrangements were still a work in progress, for example at the Delivery Board there was only one Local Authority representative and the most effective way to include Local Authorities was yet to be determined.

Residents of West Berkshire would be most interested in the commitment to review community hospitals. However, West Berkshire had a fantastic community hospital with a new renal unit being constructed; the plan would be to continue to expand and develop West Berkshire Community Hospital.

Councillor Graham Jones thanked Cathy Winfield for offering clarity on the financial aspects of the STP.

Alison Foster expressed concern that there was no lay engagement within the STP governance structure. Cathy Winfield advised that one of the sub-groups was a Patient and Public Engagement Group which included membership from Healthwatch. Alison Foster expressed the view that there was a lack of visibility and asked what had been done locally to raise awareness of the STP. Cathy Winfield advised that in the summer of 2016 there had been the 'Let's Talk' call to action and once the STP was made public the golden thread would be revealed.

Paul Jones asked what the implications would be for the Royal Berkshire Fire and Rescue Service and Thames Valley Police who worked on different footprints to the Buckinghamshire, Oxfordshire and Berkshire West footprint. Cathy Winfield advised that there would be some overlaps between footprints, for example Milton Keynes came under the Central Bedfordshire STP footprint.

Cathy Winfield concluded by stating that the document would be released to the public before Christmas.

RESOLVED that the presentation be noted.

27 Members' Questions

There were no Member Questions submitted to the Board.

28 Future meeting dates

The next meetings of the Board would take place on:

- 26th January 2017 (Development Session)
- 30th March 2017

Garry Poulson thanked the Board members for his introduction as the new voluntary sector representative. He explained that whilst he could not speak on behalf of every organisation he would attend meetings and listen carefully to the matters being discussed for key messages to feedback to other organisations. He would consider upcoming agenda items and invite other voluntary sector colleagues as required. Councillor Graham Jones stated that he could not think of a better person to represent the voluntary sector.

(The meeting commenced at 9.30am and closed at 11.17am)

CHAIRMAN …….

Date of Signature …….

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Health and Wellbeing Board Forward Plan 2017/18

Item	Purpose	Action required by the H&WB	Deadline date for reports	Lead Officer/s	Those consulted	Is the item Part I or Part II?
27th April 2017- Health and Wellbeing Conference (Shaw House)						
25th May 2017 - Board meeting						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	12th May 2017	Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Steering Group	Part I
Programme Management						
Report from the Steering Group on the Status of Current Activity	To provide exception reports for activity in the health, social care and community resilience system.	For information and discussion	16th May 2017	Bal Bahia/ Jo Reeves	Health and Wellbeing Steering Group	Part I
Medium Term Objectives - Deep Dive	Update on progress with the five objectives.	For information and discussion	16th May 2017	tbc	Health and Wellbeing Steering Group	Part I
Alcohol Harm Reduction	For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's strategic focus to 'reduce alcohol related harm across the district for all age groups'.	For information and discussion	16th May 2017	Debi Joyce	Health and Wellbeing Steering Group	Part I
Community Conversations	For the Stronger Communities Partnership to provide an update on progress against the Board's strategic focus to 'increase the percentage of communities where community conversations have successfully run and local action plans have been jointly developed'.	For information and discussion	16th May 2017	tbc	Health and Wellbeing Steering Group	Part I
Health and Social Care Integration	For the Locality Integration Board to provide an update on integration activity at the Berkshire West and BOB level.	For information and discussion	16th May 2017	Tandra Forster/ Shairoz Claridge	Health and Wellbeing Steering Group	Part I
Strategic Matters						
Children's Delivery Group Annual Report 206/17	For the report to recieve a report from the Children's Delivery Group on activity ove rthe last 12 months.	For information and discussion	16th May 2017	TBC	Health and Wellbeing Steering Group	Part I
Annual Report from the Director for Public Health	For the Board to recieve the Annual Report from the Director for Public Health	For information and discussion	16th May 2017	Lise Llewellyn	Health and Wellbeing Steering Group	Part I
Skills and Enterprise Partnership	For the Board to recieve a presentation from the Chair of the Skills and Enterprise Partnership	For information and discussion	16th May 2017	Anne Murdoch	Health and Wellbeing Steering Group	Part I
A Safe Place'	For X from RBFRS to present the Board with information regarding the new Safety Centre in Wiltshire	For information and discussion	16th May 2017	RBFRS	Health and Wellbeing Steering Group	Part I
Consultation and Communication						
Communications Forward Plan	For the Board to consider the Communications Forward Plan.	For information and discussion	16th May 2017	TBC	Health and Wellbeing Steering Group, Patient and Public Engagement Group	Part I
29th June 2017- Health and Wellbeing Problem Solving Session, Delayed Transfers of Care (Shaw House)						
6th July 2017 Development Session						
System Resilience conversation	For members of the Board to share good news and challenges facing their organisations.	For discussion	23rd June 2017			
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	23rd June 2017	Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Steering Group	
Opportunities for integration between WBC, CCG and RBFRS		For information and discussion	23rd June 2017			
Housing	For the Board to discuss the role of housing in the Health and Wellbeing Strategy	For discussion	23rd June 2017		Health and Wellbeing Steering Group	

28th September 2017 - Board meeting						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	15th September 2017	Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Steering Group	Part I
Programme Management						
Report from the Steering Group on the Status of Current Activity	To provide exception reports for activity in the health, social care and community resilience system.	For information and discussion	19th September 2017	Bal Bahia/ Jo Reeves	Health and Wellbeing Steering Group	Part I
Medium Term Objectives - Deep Dive	Update on progress with the five objectives.		19th September 2017	tbc	Health and Wellbeing Steering Group	Part I
Alcohol Harm Reduction	For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's strategic focus to 'reduce alcohol related harm across the district for all age groups'.		19th September 2017	Debi Joyce	Health and Wellbeing Steering Group	Part I
Community Conversations	For the Stronger Communities Partnership to provide an update on progress against the Board's strategic focus to 'increase the percentage of communities where community conversations have successfully run and local action plans have been jointly developed'.		19th September 2017	Susan Powell	Health and Wellbeing Steering Group	Part I
Health and Social Care Integration	For the Locality Integration Board to provide an update on integration activity at the Berkshire West and BOB level.		19th September 2017	Tandra Forster/ Shairoz Claridge	Health and Wellbeing Steering Group	Part I
Strategic Matters						
Local Safeguarding Childrens Board Annual Report	For the Board to note the annual report from the Local Childrens Safeguarding Board		19th September 2017		Health and Wellbeing Steering Group	
Delayed Transfers of Care	For the Board to consider the outcomes from the OSMC task group and Hot Focus Session on Delayed Transfers of Care.	For information and discussion	19th September 2017	TBC	Health and Wellbeing Steering Group	Part I
Consultation and Communication						
Communications Forward Plan	For the Board to consider the Communications Forward Plan.		19th September 2017	tbc	Health and Wellbeing Steering Group, Patient and Public Engagement Group	Part I
19th October 2017- Health and Wellbeing Problem Solving Session, topic tbc (Shaw House)						
29th November 2017 Development Session						
System Resilience conversation	For members of the Board to share good news and challenges facing their organisations	For discussion		All		
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	10th November 2017	Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Steering Group	Part I
Draft Health and Wellbeing Board Annual Report 2017	For the Board to consider the draft Annual Report for 2017		14th November 2017	Cllr Graham Jones		Part I
25th January 2018 - Board meeting						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	12th January 2018	Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Steering Group	Part I
Programme Management						
Report from the Steering Group on the Status of Current Activity	To provide exception reports for activity in the health, social care and community resilience system.	For information and discussion	16th January 2018	Bal Bahia/ Jo Reeves	Health and Wellbeing Steering Group	Part I
Medium Term Objectives - Deep Dive	Update on progress with the five objectives.		16th January 2018	tbc	Health and Wellbeing Steering Group	Part I
Alcohol Harm Reduction	For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's strategic focus to 'reduce alcohol related harm across the district for all age groups'.		16th January 2018	Debi Joyce	Health and Wellbeing Steering Group	Part I
Community Conversations	For the Stronger Communities Partnership to provide an update on progress against the Board's strategic focus to 'increase the percentage of communities where community conversations have successfully run and local action plans have been jointly developed'.		16th January 2018	Susan Powell	Health and Wellbeing Steering Group	Part I
Health and Social Care Integration	For the Locality Integration Board to provide an update on integration activity at the Berkshire West and BOB level.		16th January 2018	Tandra Forster/ Shairoz Claridge	Health and Wellbeing Steering Group	Part I
Strategic Matters						
Health and Wellbeing Board Annual Report 2017	For the Board to present its Annual Report for 2017		16th January 2018	Cllr Graham Jones	Health and Wellbeing Steering Group	Part I
Safeguarding Adults Annual Report 2016/17			16th January 2018	Sue Brain	Health and Wellbeing Steering Group	
Consultation and Communication						
Communications Forward Plan	For the Board to consider the Communications Forward Plan.		16th January 2018		Health and Wellbeing Steering Group, Patient and Public Engagement Group	Part I

22nd February 2018- Health and Wellbeing Problem Solving Session, topic tbc (Council Chamber)						
29th March 2018 Development Session						
System Resilience conversation	For members of the Board to share good news and challenges facing their organisations	For discussion	16th January 2018	All		
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion		Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Steering Group	Part I
24th May 2018 - Board meeting						
System Resilience						
Health and Social Care Dashboard	To present the Dashboard and highlight any emerging issues	For information and discussion	11th May 2018	Tandra Forster/Shairoz Claridge/Rachael Wardell	Health and Wellbeing Steering Group	Part I
Programme Management						
Report from the Steering Group on the Status of Current Activity	To provide exception reports for activity in the health, social care and community resilience system.	For information and discussion	15th May 2018	Bal Bahia/ Jo Reeves	Health and Wellbeing Steering Group	Part I
Medium Term Objectives - Deep Dive	Update on progress with the five objectives.		15th May 2018	tbc	Health and Wellbeing Steering Group	Part I
Alcohol Harm Reduction	For the Alcohol Harm Reduction Partnership to provide an update on progress against the Board's strategic focus to 'reduce alcohol related harm across the district for all age groups'.		15th May 2018	Debi Joyce	Health and Wellbeing Steering Group	Part I
Community Conversations	For the Stronger Communities Partnership to provide an update on progress against the Board's strategic focus to 'increase the percentage of communities where community conversations have successfully run and local action plans have been jointly developed'.		15th May 2018	tbc	Health and Wellbeing Steering Group	Part I
Health and Social Care Integration	For the Locality Integration Board to provide an update on integration activity at the Berkshire West and BOB level.		15th May 2018	Tandra Forster/ Shairoz Claridge	Health and Wellbeing Steering Group	Part I
Strategic Matters						
tbc			15th May 2018		Health and Wellbeing Steering Group	
Consultation and Communication						
Communications Forward Plan	For the Board to consider the Communications Forward Plan.		15th May 2018	tbc	Health and Wellbeing Steering Group, Patient and Public Engagement Group	Part I

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Title of Report:	**Mental Health Focus**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	30 March 2017

Purpose of Report:

To provide the Health and Wellbeing Board's guest, Richard Benyon MP, and the residents of West Berkshire an overview of activity to support mental health and wellbeing at the Berkshire, Berkshire West and West Berkshire levels.

Recommended Action:

The West Berkshire Health and Wellbeing Board pledge to develop and implement an action plan to build on the commitment it has made in its refreshed Strategy to support mental health and wellbeing throughout life.

The Health and Wellbeing Board approve the adoption of the Berkshire Suicide Prevention Strategy.

The Health and Wellbeing Board considers the information presented on the Berkshire West Mental Health Strategy 2016-2021 and provide direction regarding specific areas of concern/priority for the West Berkshire population.

The Health and Wellbeing Board note the progress of the refreshed Local Transformation Plan for Children and Young People's Emotional Health and Wellbeing.

The Health and Wellbeing Board note the progress of the Mental Health Collaborative to support the aim in the Health and Wellbeing Strategy to 'support mental health and wellbeing throughout life'.

Reason for decision to be taken: For the Board to influence and endorse activity to support the mental health and wellbeing of West Berkshire's residents.

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Contact Officer Details – Berkshire Suicide Prevention Strategy	
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Contact Officer Details – Berkshire West Mental Health Strategy	
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Contact Officer Details – West Berkshire Mental Health Collaborative	
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Executive Report

1. Introduction

1.1 The provision of healthcare services to residents in West Berkshire happens in a complex geography:

(1) **Berkshire** – refers to the six local authority areas which make up the county of Berkshire, including Slough, the Royal Borough of Windsor and Maidenhead, Bracknell Forest, Wokingham, Reading and West Berkshire. The authorities share a Public Health team.

(2) **Berkshire West** – refers to the local authorities, Clinical Commissioning Groups and NHS providers who serve Reading, Wokingham and West Berkshire.

(3) **West Berkshire** – refers to the area covered by West Berkshire Council, stretching from areas of Calcot and Tilehurst in the East of the District to Lambourn in the West.

1.2 So that the Health and Wellbeing Board can be assured of the work being undertaken at each of these different levels, it has decided to focus on activity to "support mental health and wellbeing throughout life", which is one of the five strategic aims in the West Berkshire Joint Health and Wellbeing Strategy 2017-2020.

Berkshire

2. Brighter Berkshire 2017

2.1 Brighter Berkshire is a community-led initiative from volunteers across public and private sectors who have come together to mobilise and excite the community to improve the mental health of people in Berkshire and increase the opportunities and choice that are available to us.

2.2 We are people who have worked in mental health services, experienced mental health issues, know people or cared for people with mental health issues.

(1) Mental health issues affect 1 in 4 people at any one time.

(2) Suicide is the biggest killer of men over 25

(3) It's the biggest killer of women in the first year after birth

(4) Over 50% of people with an adult diagnosis of mental health issue were known before age of 14.

2.3 68 people killed themselves in Berkshire last year, 2/3 of them were not in touch with services leading up to their decision to take their life. Many feel like this now. This demonstrates the impact of stigma for many people still in accessing help. This issue is getting worse. We also have reductions in public service spending. But there is not a reduction in money in the local system with parts of Berkshire for example being the fastest growing economy outside of London.

2.4 By bringing together a range of people across the county we could facilitate the growth of networks of support and in so doing we hope to

(1) raise awareness and understanding of mental wellbeing, mental illness and recovery, by increasing the conversation on mental health in all aspects of life

(2) reduce the stigma attached to mental health

(3) increase the awareness of the local opportunities for people who have challenges linked to mental health

2.5 A list of the primary aims for the next year and examples of what is already happening across Berkshire is provided in Appendix A.

2.6 It is proposed that the Health and Wellbeing Board pledge to develop and implement an action plan to build on the commitment it has made in its refreshed Strategy to support mental health and wellbeing throughout life.

3. Draft Berkshire Suicide Prevention Strategy

3.1 The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. To achieve this, the Department of Health has recommended, in the National Suicide Prevention Strategy, that all top tier local authorities produce suicide prevention actions plans. In Berkshire, this has been coordinated by a multi-agency suicide prevention group who have drafted a strategy which includes a Berkshire-wide action plan, and local action plans responding to the unique needs and circumstances of each of the six unitary authorities in Berkshire. The action plans are reliant on multi-agency working and partners across the health and public sectors are in the process of endorsing the strategy.

3.2 Berkshire Authorities had not published a suicide prevention action plan at the time of the 2015 All Party Parliamentary Group inquiry into local suicide prevention plans in England. Action plans were a recommendation of the England Suicide Prevention Strategy published in 2012. Since 2015, a high-level multi-agency steering group have met in Berkshire to plan a local audit of suicides and to work together on a strategy and action plans for the local authorities. This draft strategy is the result of this work and a recommendation of the strategy is that all six local health and wellbeing boards endorse the strategy and their local action plans.

3.3 The full strategy is provided in Appendix B.

3.4 It is proposed that the Health and Wellbeing Board approve the Berkshire Suicide Prevention Strategy.

Berkshire West

4. Berkshire West Mental Health Strategy 2016-2021

4.1 The paper at Appendix C was provided to the Berkshire West 10 Integration Delivery Group on 25 January 2017, and subsequently to the Berkshire West Integration Board on 15 February 2017. This followed the request from the Integration Board, that the Delivery Group consider the current status of mental health services in Berkshire West.

4.2 The Delivery Group considered the paper, which is structured in line with the Board request to look at what is going well, what are our challenges, and recommendations about the next steps we should take to ensure mental health is appropriately included within our overall approach to integration as a system.

4.3 The Delivery Group endorsed the analysis outlined by the paper, and agreed that the following additional elements should be included in future work:

(1) That proper consideration is given to the health inequalities experienced by people with mental health problems – specifically in terms of significantly reduced life expectancy

(2) That service provision for adults with autism and ADHD should be included in future plans

(3) That desired outcomes should be built into our implementation plans

4.4 The recommended next steps were endorsed by the Delivery Group:

(1) H&WB Board discussions on Mental Health in each area to clarify local priorities, and approach to strategy implementation.

(2) Berkshire West Strategy Steering Group established with representatives linked to local governance arrangements appropriate to each area.

(3) Inclusion of Berkshire West key projects in Delivery Group monitoring, along with progress in reducing delayed transfers of care from MH Inpatient Services. N.B. this is not intended to duplicate existing reporting e.g. through A&E Delivery Board.

4.5 These recommendations were supported by the Integration Board at its meeting on 15 February 2017, and therefore the paper is being presented to the West Berkshire Health and Wellbeing Board in line with recommendation 1.

4.6 Subsequent to the Integration Board meeting, a discussion has taken place with the lead for the “Brighter Berkshire” campaign, and work is in progress to ensure that there are effective links between the mental health promotion aims of this initiative and that of the mental health strategy.

4.7 The Health and Wellbeing Board is asked to consider the information presented and provide direction regarding specific areas of concern/priority for the West Berkshire population. (These will be collated with feedback from Reading and

Wokingham Health and Wellbeing Boards and brought forward into the work of the Berkshire West Strategy Steering Group.)

4.8 Guidance regarding frequency of ongoing reporting of progress is also requested from the Health and Wellbeing Board. (It is suggested that this takes place twice yearly.)

West Berkshire

5. West Berkshire Mental Health Collaborative

5.1 The Mental Health Collaborative (MHC) originally started as a sub group of the monthly West Berkshire Mental Health Forum but then expanded to include other organisations who did not attend the Forum on a regular basis but still had an interest in mental health (for example; Citizen's Advice Forum, Sovereign Housing).

5.2 The MHC consists of a range of people from different organisations including sovereign housing, CAB, CCG, Talking Therapies, CMHT, voluntary sector, service users and staff from local mental health support groups (friends in need, 8 bells, Pulling together) all with an interest and knowledge of mental health services.

5.3 The aim of the MHC is to help to develop a strategic approach to mental health through joint working and allowing everyone to contribute and have a say. The MHC has now met several times, commencing with workshops in 2014 and 2015 to set out a vision and focus on key issues. From this, a workshop to develop an action plan took place.

5.4 Originally, the group remit was solely on adult mental health, as the mental health forum is just for adults but the MHC became a sub group of the Health and Wellbeing Board and in September 2015, they tasked the group with developing a Mental Health Strategy that includes a focus on children and young people as well as adults.

5.5 A draft mental health strategy was circulated in November 2015 but it was felt by the mental health collaborative that more work needed to be done on the strategy.

5.6 The MHC had no experts on children and young people so invites were sent to some key people who attending meetings in May 2016, September 2016 and November 2016 and January 2016.

5.7 Since May 2016, the MHC has become more focused on writing the mental wellbeing strategy. At the meeting on 19th May the collaborative decided to take that forward by breaking into sub-groups, each looking at a different stage of life, starting well (under 18s) living well (18 to 64s) and ageing well (over 65s). The aim of each sub group is to address their specific areas and come up with statements and suggestions on how mental health provision could be improved. Each sub group has people who write (author) or review their section of the strategy.

5.8 There is a proposed format of the strategy and each of the subgroups are writing sections on; mental health literacy, prevention and promotion, age 0 to 3 and right care, right time, right service.

5.9 All members of the MHC have access to an online platform, Huddle, where the editing and saving of documents can be done in one place. This avoids the need of having to email documents to each other and lose version control. Policy and other strategic documents can also be stored on Huddle for easy access.

5.10 Members of the Children's Delivery Group are being asked to comment on the Starting Well section which is being written by Public Health and Wellbeing, using information from the Local Transformation Plan and other relevant documents.

5.11 A mental wellbeing strategy consultation event was held on Monday 20th March, Shaw House, Church Rd, Newbury RG14 2DR, 9.30am to 12.30pm. To ensure more input from a diverse group of service users, small discussion groups was held with those with experience of mental health services, to enhance the strategy as well as address any adverse impact on specific groups; based on race, gender, disability and so forth. A suggestion was made that people from Faith groups should be consulted with.

5.12 Once the strategy has been written, there will be a workshop to develop an action plan, which will contain short, medium and long term goals. This will also align to the action plan for the Health and Wellbeing Strategy and will be monitored regularly.

6. West Berkshire Suicide Prevention Action Plan

6.1 At the meeting held on 2nd March, the Health and Wellbeing Board Steering group were supportive of the Berkshire Suicide Prevention strategy and were keen to identify how we were going to deliver the strategy locally and how we will make a difference in West Berkshire. To address these questions, a meeting was held on 9th March 2017 between Rachel Johnson (Chair of the Mental Health Collaborative), Garry Poulson (Director of volunteer Centre West Berkshire) and Jo Reeves (Principal Policy Officer) to look at the Berkshire Suicide Prevention Strategy and West Berkshire Suicide Prevention Action plan. It was felt that the action plan needed to be driven with support from the local community and voluntary sector. In this way, the work would be the responsibility of everyone and not just become a council owned initiative.

6.2 The action plan was reviewed and there was agreement that the monitoring and implementation of the suicide prevention strategy and local action plan should be separate from the mental health collaborative.

6.3 There was a proposal put forward that a West Berkshire suicide prevention working group would be formed, chaired by the Director of the volunteer centre. Administration of the group would fall to the volunteer centre. Membership of this working group would be different to the mental health collaborative and aimed at organisations that have direct contact with men who are at risk of suicide (for example, Samaritans, National Farmers Union, Young Farmers, Injured Jockeys, Racing Welfare).

6.4 At the meeting, it was suggested that the working group could focus on 3 out of the 6 areas within the action plan;

(1) Reduce the risk of suicide in key high-risk groups

(2) Provide better information and support to those bereaved or affected by suicide

(3) Support the media in delivering sensitive approaches to suicide and suicidal behaviour

6.5 The following areas would be picked up elsewhere;

(1) Tailor approaches to improve mental health in specific groups (Mental Health Collaborative)

(2) Reduce access to the means of suicide (Berkshire wide work with Support Network Rail, British Transport Police)

(3) Support research, data collection and monitoring (the update of the JSNA will be done by Public Health)

6.6 One or two priorities within each of the three areas of the action plan will be identified, for example having a focus on men for the first year. The group had a preliminary discussion on the actions that could be undertaken by the working group; a general suicide awareness raising campaign, encouraging men to talk and seek help, implementing a specific campaign targeting men at risk of social isolation (for example, Men in Sheds) and considering how to link in with Brighter Berkshire.

7. Conclusion

7.1 This report provides a snapshot of activity being undertaken to support people with their mental health and wellbeing in West Berkshire and should be read in association with its appendices.

7.2 The Health and Wellbeing Board should consider whether these activities are aligned and whether they fully recognise and support local issues.

Appendices

Appendix A – Brighter Berkshire 2017
Appendix B – Draft Berkshire Suicide Prevention Strategy
Appendix C - Integration and Mental Health: Briefing for Berkshire West 10 Delivery Group

Consultees

Local Stakeholders: Health and Wellbeing Steering Group

Officers Consulted: n/a

Trade Union: n/a

Brighter Berkshire

2017 Year of Mental Health

Brighter Berkshire is a community-led initiative from volunteers across public and private sectors who have come together to mobilise and excite the community to improve the mental health of people in Berkshire and increase the opportunities and choice that are available to us.

We are people who have worked in mental health services, experienced mental health issues, know people or cared for people with mental health issues.

- Mental health issues affect 1 in 4 people at any one time.
- Suicide is the biggest killer of men over 25
- It's the biggest killer of women in the first year after birth
- Over 50% of people with an adult diagnosis of mental health issue were known before age of 14.

68 people killed themselves in Berkshire last year, 2/3 of them were not in touch with services leading up to their decision to take their life. Many feel like this now. This demonstrates the impact of stigma for many people still in accessing help. This issue is getting worse. We also have reductions in public service spending. But there is not a reduction in money in the local system with parts of Berkshire for example being the fastest growing economy outside of London.

By bringing together a range of people across the county we could facilitate the growth of networks of support and in so doing we hope to

- raise awareness and understanding of mental wellbeing, mental illness and recovery, by increasing the conversation on mental health in all aspects of life
- reduce the stigma attached to mental health
- increase the awareness of the local opportunities for people who have challenges linked to mental health

Our primary aims for the next year are:

As a group of volunteers, we have already engaged the community in a very different way, growing our volunteer base all the time. We are reaching out to our own networks to get involved and we are actively using social media to promote our cause and engage the Berkshire community.

We have received support from all Berkshire councils, BHFT and CCGs as well as support from Newbury College, Reading College and Reading University. Businesses such as Cisco, Reading Football Club, and Watermill Theatre are getting involved too.

We are launching our partnership with Berkshire Community Foundation on 16th March. Following the release of the Foundation's recent Vital Signs report, BCF announced that mental health is their main focus for 2017 so are joining forces with Brighter Berkshire to make a lasting difference. Together we raise funds for mental health causes and deliver a legacy fund for local mental health charities.

We are encouraging people, teams and organisations to pledge to do just one thing that might help make a difference. These include offering free venues, providing mental health first aid training and simply pledging to talk openly about mental health within networks.

Brighter Berkshire
2017 Year of Mental Health

Below are a few examples of how this is already happening across Berkshire:

- We are launching a song writing competition in partnership with Pete Doyle, founder of Rock Academy Foundation, across Berkshire secondary schools to encourage discussion and awareness of mental health with 11-18 year olds
- Reading Spaces have offered to run a public art exhibition on mental health
- We are working to create a Berkshire wide bike ride – where participants wear the same BB tee-shirts with mental health messages, stopping in key town areas for photo opportunities
- Working with Reading College and their students to involve them in Brighter Berkshire. They have been researching mental health and have been set projects to evaluate our branding, and create information leaflets to be circulated around town centres.
- We have partnered with BBC Radio Berkshire and have a monthly show called Talking Heads - hosted entirely by people with lived experience of mental health challenges. They share their own stories, interview callers and other related guests.
- We are connecting people and resources from different networks to create their own opportunities and awareness independently
- Book review organisation will share and review books on mental health and organizing a book signing event
- As part of our work to increase awareness of opportunities that are already available but perhaps aren't that well known, we are creating an 'Asset Map' for all community run mental wellbeing services available in the Berkshire area
- We are hoping to host an award ceremony towards the end of the year to celebrate the amazing work that is going on, and to incentivise businesses, clubs and individuals to get involved and do something positive for mental health in Berkshire
- We have a £1 per employee scheme running. The costs of mental health related issues to businesses are estimated to cost businesses £1,000 per employee per year. We are calling on businesses to donate £1 per employee and collectively make a big impact locally
- Walking groups will bring people together using physical exercise and socialising while we also spread the word about it being a year of mental health. We hope people gather at one end of a busy town centre street, pair up and visit the town's shops, cafes and restaurants with postcards and ask they sign up to to get involved with our year of mental health. We hope this will be a fun, healthy and social experience.

Public Health Services for Berkshire

Berkshire Suicide Prevention Strategy 2017-2020

Full Version with Audit & Action Plans

DRAFT V9

Darrell Gale FFPH

Consultant in Public Health

Mental Health Lead Consultant for Berkshire

NB: All comments in red are instructions to help guide the final drafting and formatting.

Logos to be added as follows:

Bracknell Forest Council	Reading Borough Council	Royal Borough of Windsor & Maidenhead	Slough Borough Council	West Berkshire Council	Wokingham Borough Council

Bracknell & Ascot NHS CCG	Newbury & District NHS CCG	North and West Reading NHS CCG	Slough NHS CCG	South Reading NHS CCG	Windsor Ascot & Maidenhead NHS CCG	Wokingham NHS CCG

Berkshire Healthcare NHS Foundation Trust	Frimley Health NHS Foundation Trust	Royal Berkshire NHS Foundation Trust

Brighter Berkshire Year of Mental Health

Contents

Acknowledgements

Acknowledgements are due to a wide range of partners and colleagues whose work; encouragement and commitment to suicide prevention has enabled the development of this strategy and its action plans. In particular, we acknowledge the following:

Rutuja Kulkarni and the public health officers from Berkshire local authorities who undertook the Suicide Audit, and who did much to build the foundations upon which this strategy has developed;

The suicide prevention and mental health leads from the Berkshire local authorities for preparing the local action plans;

Network Rail and British Transport Police for their support with work on railway suicides;

Helena Fahie at Public Health England South East Centre for encouragement; advice and going the extra mile;

David Colchester at the Local Criminal Justice Board for the Thames Valley and Thames Valley Police for their input on real-time surveillance;

The NHS Provider trusts in Berkshire for their input and continued support;

The seven Clinical Commissioning Groups in Berkshire for their strong partnership working;

and of course all past and present members of the Berkshire Suicide Prevention Steering Group.

Executive Summary

The NHS Five Year Forward View for Mental Health sets a target on all NHS agencies and partners to reduce the current level of suicide by 10% by 2020. This is a laudable and hopefully readily achievable aim. However as discussions across the range of organisations which have contributed to this strategy have progressed, it appears to many, that this aim is not challenging enough. Zero Suicide should be our aim; as it is in the gift of the combined efforts of these organisations, and of society at large, to put in place the policies and services which protect people from mental distress, and to ease the factors which cause that distress. This strategy therefore forges ahead with an ambitious stretch target to reduce suicide by at least 25% by 2020, thus ensuring that this becomes a shared priority across organisations and areas.

We recognise that a Berkshire without suicide is the true aim we work towards.

This strategy is an important public health strategy which seeks to save lives lost to suicide through its prevention, and to improve the health and wellbeing of those bereaved by suicide. It also includes more general whole-population actions aimed at improving mental health and wellbeing as contributing factors that prevent suicide. The strategy highlights, and action plans prioritise, certain population groups which have greater risk factors for suicide, and thus contributes to narrowing health inequalities.

It goes without saying, but we should remind ourselves, that suicides are tragedies for all involved. For every person who dies by suicide at least 10 people are directly affected. Support for those bereaved, including the professionals who deal with the suicide, is vitally important. The social and economic cost of a suicide is substantial. The average cost of suicide in someone of working age in England is estimated to be £1.67 million. This includes direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering of those bereaved or affected by suicide.

Many stakeholders have contributed to this strategy and it should now be adopted as a joint strategy by each of the CCGs, Local Authorities, and the Health and Wellbeing Boards in Berkshire. It should also be referenced and reflected in other plans and strategies when they are drafted or re-written, to ensure suicide prevention becomes a pursuit common to all agencies and professions. It is an important and happy coincidence that this strategy will be formally launched, once it has been endorsed by all health and wellbeing boards in Berkshire, during Brighter Berkshire, the Year of Mental Health. This community led initiative aims to help increase the opportunities and support for our Berkshire population who need help with their mental health, when they need it and to build a stronger happier Berkshire population. The aims of this strategy fit well with these broader aims.

Dr Lise Llewellyn
Strategic Director of Public Health for Berkshire April 2017

RECOMMENDATION
Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

Recommendations

The following recommendations are the principle strategic objectives for Berkshire as a whole. These link through into more detailed action plans for Berkshire-wide work and for local authority areas. In line with the national suicide prevention strategy, the main outcomes of this strategy are to reduce suicides in Berkshire by 25% by 2020, and to provide better support for those bereaved or affected by suicide. The national strategy has identified six priority areas and the recommendations linked to these are outlined below, following those relating to the overarching aims.

Over-arching Recommendations

RECOMMENDATION
That this Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

RECOMMENDATION
That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

RECOMMENDATION
Sign off / endorsement of this strategy by all Health & Wellbeing Boards in Berkshire.

RECOMMENDATION
Launch this strategy at a multi-agency suicide prevention summit, by October 2017.

RECOMMENDATION
Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Priority Areas

1. Reduce the risk of suicide in key high-risk groups;

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

2. Tailor approaches to improve mental health in specific groups;

RECOMMENDATION
Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

3. Reduce access to the means of suicide;

RECOMMENDATION
That local authority public health teams take the leadership for liaison with any Escalation Process in their area, and report on progress to the Steering Group.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

4. Provide better information and support to those bereaved or affected by suicide;

RECOMMENDATION
Ensure bereavement information and access to support is available to those bereaved by suicide, including professionals involved in the case.

5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour;

RECOMMENDATION
Liaise with local media to encourage reference to and use of guidelines for the reporting of suicide through a summit with local press and media organisations, and to provide information to professionals on the sensitive reporting of suicide. By 20 July 2017

6. Support research, data collection and monitoring.

RECOMMENDATION
Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Background

Suicide is a devastating event. It is an individual tragedy, a life-altering crisis for those bereaved, and a traumatic event for communities and services. The impacts are immediately and profoundly distressing. We thus need to be sure that in the Clinical Commissioning Groups (CCGs) and Local Authorities in Berkshire, an alliance of stakeholders takes preventive and ongoing action covering the main risks. The 2012 national strategy ('Preventing Suicide in England') sets us two major objectives: reducing the suicide rate in England, and giving better support to people bereaved or affected by suicide. Those objectives are thus given priority in this strategy.

Suicide is not inevitable. Preventing suicides is a complex and challenging issue, but there are effective solutions for many of the individual factors which contribute towards the risk of suicide. Suicide Prevention work is cost-effective when conducted in accordance with evidence of effectiveness, and by working in partnership. Local Government, statutory services, the third sector, local communities and families each have a role to play.

Whilst suicide causes a vast negative wellbeing impact on family, friends, colleagues, and wider contacts, they also have a huge economic impact. The average cost of a single completed suicide of a working age individual in England was estimated in 2012 to be more than £1.5 million. This includes intangible costs (loss of life to the individual and the pain and suffering of relatives), as well as waged and unwaged lost output, public service time and funeral costs. Non-fatal self-harm also has major – potentially avoidable - cost implications for public services, particularly A&E and acute inpatient services and psychiatric follow-up.

Suicides are not inevitable and are a major issue for society as well as being a leading cause of years of life lost. There are many ways in which services, communities, individuals and society as a whole can help to prevent suicides. Government and statutory services have a role to play in building individual and community resilience. Vulnerable people in the care of health and care services can be supported and kept safe from preventable harm. Interventions can be provided quickly when someone is in distress or in crisis and for vulnerable people in the wider community, practical measure such as debt advice services can make all the difference.

Public Health England (PHE) has recently published a guide to local suicide prevention planning (2016). In it, they identify ten things that everyone needs to know about suicide prevention. These are re-produced here in full, and with kind permission of PHE. Simple to follow and understand, these form the basis of raising awareness of suicide prevention across Berkshire services and populations.

10 Things Everyone Needs To Know About Suicide Prevention

1 Suicides take a high toll

There were 4,882 deaths from suicide registered in England in 2014 and for every person who dies at least 10 people are directly affected.

2 There are specific groups of people at higher risk of suicide

Three in four deaths by suicide are by men. The highest suicide rate in England is among men aged 45-49. People in the lowest socio-economic group and living in the most deprived geographical areas are 10 times more at risk of suicide than those in the highest socio-economic group living in the most affluent areas.

3 There are specific factors that increase the risk of suicide

The strongest identified predictor of suicide is previous episodes of self-harm. Mental ill-health and substance misuse also contribute to many suicides. Suicide prevention strategies must consider and link to programmes of early identification and effective management of self-harm, mental ill-health and substance misuse.

4 Preventing suicide is achievable

The delivery of a comprehensive strategy is effective in reducing deaths by suicide through combining a range of integrated interventions that build community resilience and target groups of people at heightened risk of suicide. Directors of public health and health and wellbeing boards have a central role. Their involvement is crucial in coordinating local suicide prevention efforts and making sure every area has a strategy in place.

5 Suicide is everybody's business

A whole system approach is required, with local government, primary care, health and criminal justice services, voluntary organisations and local people affected by suicide having a role to play. Suicide prevention can also be part of work addressing the wider determinants of health and wellbeing.

6 Restricting access to the means for suicide works

This is one of the most evidenced aspects of suicide prevention and can include physical restrictions, as well as improving opportunities for intervention.

7 Supporting people bereaved by suicide is an important component of suicide prevention strategies

Compared with people bereaved through other causes, individuals bereaved by suicide have an increased risk of suicide and suicidal ideation, depression, psychiatric admission as well as poor social functioning.

8 Responsible media reporting is critical

Research shows that inappropriate reporting of suicide may lead to imitative or 'copycat' behaviour.

9 The cost of suicide justifies investment in suicide prevention work

The economic cost of each death by suicide of someone of working age is estimated to be £1.67 million. This covers the direct costs of care, indirect costs relating to loss of productivity and earnings, and the intangible costs associated with pain, grief and suffering.

10 Local suicide prevention strategies must be informed by evidence

Local government should consider the national evidence alongside local data and information to ensure local needs are addressed.

Strategy Aims

In 2014, the seven Berkshire CCGs and six local authority public health teams across Berkshire began work to refresh the suicide audits previously undertaken and to recommend from this a strategy for reducing suicide risk across Berkshire. This strategy is the result of a study of national research and recommendations plus recommendations of many local stakeholders from a range of organisations.

This strategy proposes co-ordinated prevention across all the elements influencing suicide, from the wider determinants of distress and escalating desperation, and poor mental health, through coordinated local preventive action spanning local authority and voluntary services, and primary and secondary care.

The overall aim of this strategy is:

- To outline how partners across the county will work to prevent suicide in Berkshire.
- To outline the governance structure for Suicide Prevention work in Berkshire.
- To make clear how the public, partners and other stakeholders can deliver the actions outlined herein.

The objectives and six priority areas to meet this aim are also drawn from the National Suicide Prevention Strategy – "Preventing Suicide in England" (DH, 2012), and are intended to be met through coordinated multi-agency actions, under the governance of the Berkshire Suicide Prevention Steering Group.

The objectives of this strategy developed from the national strategy are:

- To aspire to reduce suicides in Berkshire by 25% by 2020;
- To ensure better support is provided for those bereaved or affected by suicide.

The priority areas of this strategy drawn from the national strategy are:

1. Reduce the risk of suicide in key high-risk groups;
2. Tailor approaches to improve mental health in specific groups;
3. Reduce access to the means of suicide;
4. Provide better information and support to those bereaved or affected by suicide;
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour;
6. Support research, data collection and monitoring.

These six priority areas have become the golden thread which runs through this strategy and the action plans which support it. These action plans are for the year 2017/18, whilst the strategy is for the years 2017-2020, taking this to the year when the overarching aim to reduce suicide by 10%, as stated in the Five Year Forward View on Mental Health and incorporated into the Sustainability and Transformation Plans produced by groups of CCGs. There are other recommendations around process and which address the overarching aims and/or a combination of the priority areas.

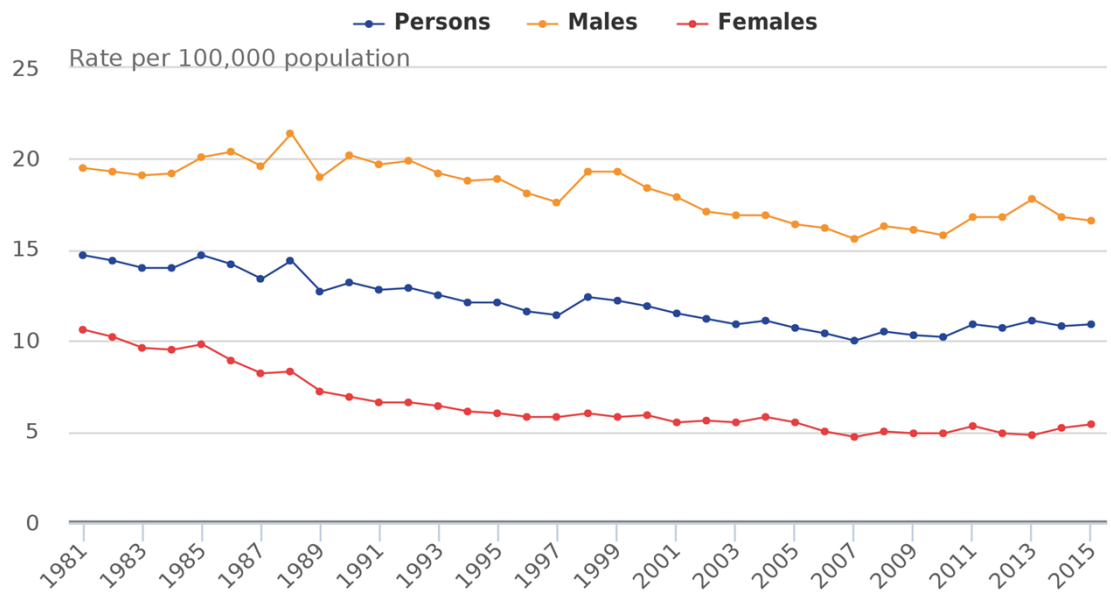
National Context

Nationally available data on suicides can help place local information on suicides in context. From the national references which include rates, trends, risk factors, suicide methods and evidence of what works to prevent suicides, a local approach for suicide prevention can be developed. This section presents the national data on suicides and is intended to be used as a guide to draw comparisons with local data and information from the Berkshire Audit.

The Office for National Statistics (ONS) provides figures on deaths by suicide, available publicly on its website at: www.ons.gov.uk. Data can be downloaded which shows numbers and rates of death by suicide per 100,000 population. Rates are important as they account for the age and size of populations, so it is more reliable when comparing suicide across age groups and areas.

Suicide is defined in England and Wales as a death with an underlying cause of intentional self-Harm and/or an injury/poisoning of undetermined intent (ICD10 codes X60-X84 - all ages and Y10-Y34 – for ages over 15 years). There is an assumption that most injuries or poisonings of undetermined intent are self-inflicted and where there is insufficient evidence to prove that the person intended to kill themselves. This assumption however is not applied to children due to the possibility that these deaths were caused by other situations – such as abuse or neglect. For this reason, data on suicides in England only include persons aged 15 years and over for deaths from injury of undetermined intent and may therefore lead to an under-reporting of deaths as a result of suicide in children.

Figure 1: Age-standardised suicide rates by sex, deaths registered between 1981 and 2015, United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

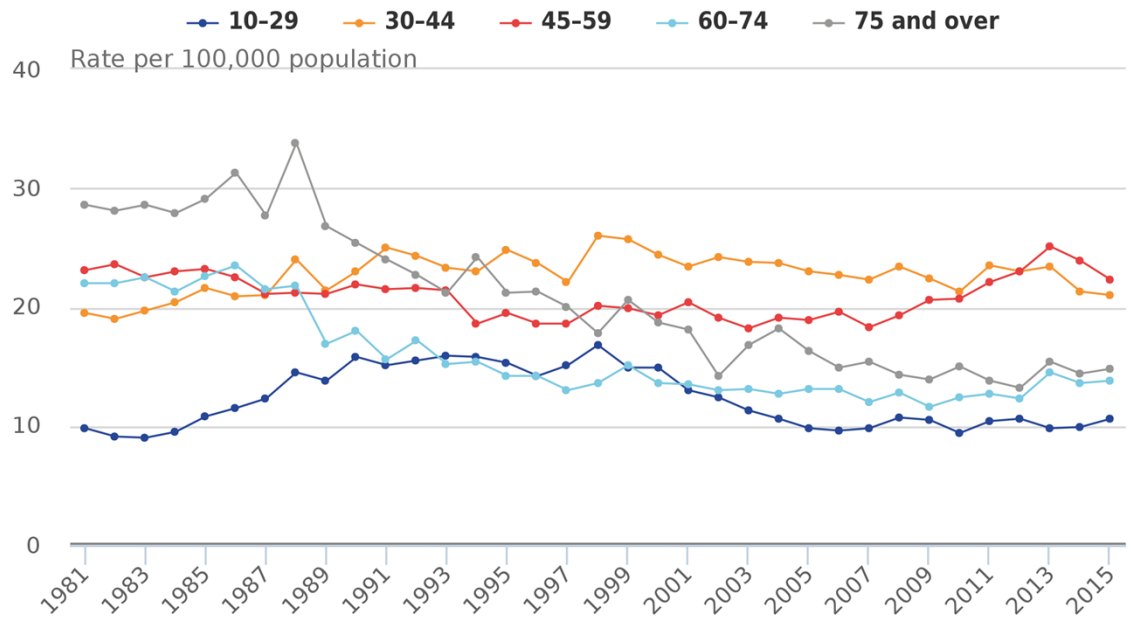
Figure 1 above shows the age standardised suicide rates for the UK since 1981. A generally downward trend in suicide rates was observed between 1981 and 2007, with a decrease from 15.6 to 10.6 deaths per 100,000 population (see figure 1). There has been a slight overall increase in suicide rates since 2007, to 10.8 per 100,000, which is part of an upward trend since 2007 for both sexes.

Suicide continues to be more than three times as common in males. The male suicide rate in 2013 was the highest since 2001. The lowest male rate since the beginning of the data series, at 16.6 per 100,000, was in 2007.

The highest suicide rate in the UK in 2015 was among men aged 45 to 59, at 22.3 deaths per 100,000, slightly lower than the record high seen in 2013. This age group also had the highest rate among women, at 7.3 deaths per 100,000 population.

Between 2000 and 2011, the rate in this age group was the second highest, behind men aged 30 to 44. Since 2007, the rate in the 45 to 59 age group has been increasing.

Figure 2: Age-specific suicide rate, males, deaths registered between 1981 and 2015, United Kingdom

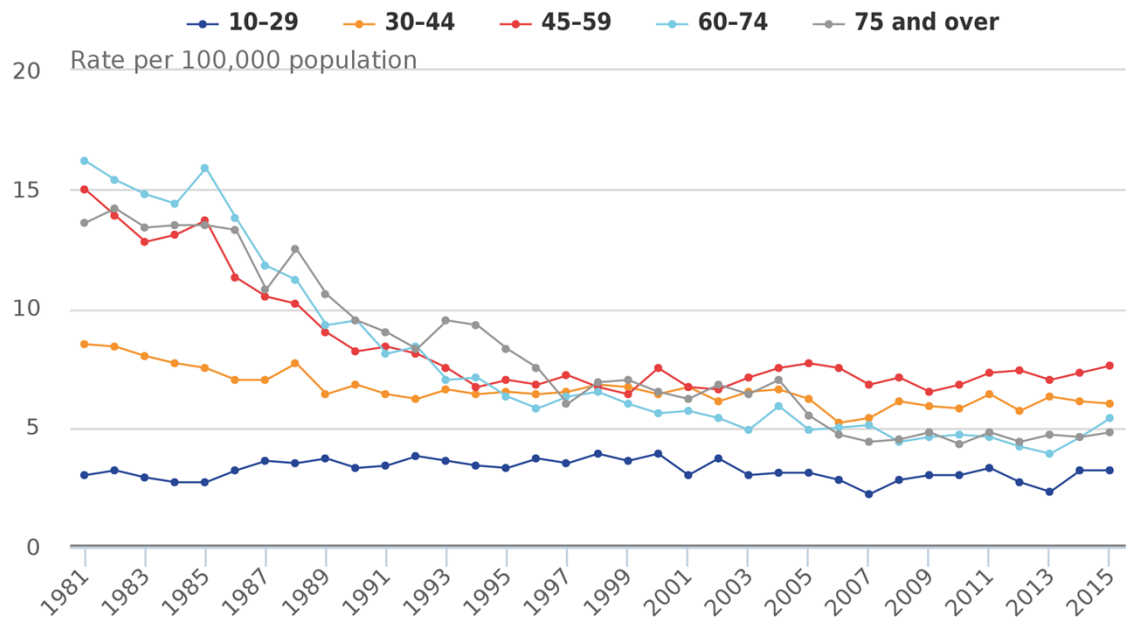


Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

Female rates have stayed relatively constant since 2007. In 2015, the age group with the highest suicide rate for females was 45- to 59-year-olds, with a rate of 7.6 deaths per 100,000 population (see Figure 3). This has been the case since 2003. Analysing this data by 5 year age group shows that females aged 50 to 54 have the highest suicide rate at 8.0 per 100,000 population. Between 1981 and 1994, female suicide rates decreased across all broad age groups apart from 10 to 29 year-olds. Suicide rates for women under 60 have remained relatively constant since 2008, and for women aged 60

and over continue to show a broadly decreasing trend,showing the biggest reduction since 1981.

Figure 3: Age-specific suicide rate, females, deaths registered between 1981 and 2015, United Kingdom



Source: Office for National Statistics, National Records of Scotland, Northern Ireland Statistics and Research Agency. 2016.

A time trend analysis in England suggested that the recent recession in the UK could be an influencing factor in the increase in suicides. The study found that local areas with greater rises in unemployment had also experienced higher rises in male suicides (Barr et al 2012). A review by Samaritans (2012) emphasised that middle-aged men in lower socioeconomic groups are at particularly high risk of suicide. They pointed to evidence that suicidal behaviour results from the interaction of complex factors such as unemployment and economic hardship, lack of close social and family relationships, the influence of a historical culture of masculinity, personal crises such as divorce, as well as a general 'dip' in subjective wellbeing among people in their midyears, compared to both younger and older people (Office for National Statistics, 2014).

Suicide by mental health in-patients continues to fall, most clearly in England where the decrease has been around 60% during 2004-14. This fall began with the removal of ligature points to prevent deaths by hanging, but has been seen in suicides on and off the ward and by all methods. Despite this success, there were 76 suicides by in-patients in the UK in 2014, including 62 in England. The 2016 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness found that: many people who died by suicide had a history of drug or alcohol misuse, but few were in contact with specialist substance misuse services; more patients who died by suicide were reported as having economic problems, including homelessness, unemployment and debt; and there has been a rise in the number of suicides by recent UK residents, i.e. those who had been in

the UK for less than 5 years, including those who were seeking permission to stay. There are twice as many suicides under crisis resolution / home treatment compared to in-patients.

Hanging, strangulation and suffocation account for the largest number of suicides in males, at 60% of the total. In females hanging and drug related poisoning are the joint most frequent methods, at 38%.

Strategic Context

Local suicide prevention planning is the responsibility of local authority public health teams to deliver with clinical commissioning groups (CCGs), health and wellbeing boards and a wider network of partners. Very recent guidance to inform this strategy has been developed by Public Health England (2016) in partnership with the National Suicide Prevention Alliance.

The need to develop suicide prevention strategies and action plans at a local level and which engage with a wide network of stakeholders in reducing suicide is set out in the government's national strategy for England, Preventing Suicide in England, a cross government strategy to save lives (HM Government, 2012). It is also reinforced by the Mental Health Taskforce's report to NHS England, *The Five Year Forward View for Mental Health* (NHS England, 2016).

Responsibility for suicide prevention action plans and strategy lies with local government through health and wellbeing boards. Local authorities report on the quality and success of initiatives to improve the health and wellbeing of their populations, using national indicators set out in the Public Health Outcomes Framework. Indicators relevant to suicide prevention include suicide rate, self-harm and excess mortality in adults aged under 75 years with serious mental illness

Around half of people who die by suicide have a history of self-harm, and self-harm is a sign of serious emotional distress in its own right. Mental health promotion, prevention and early intervention are essential to help reduce self-harm in the community that does not present to health services. The effective assessment and management of self-harm by NHS services where people do present with self-harm, particularly in Emergency Departments, represents a huge opportunity to reduce repetition of self-harm and future suicide risk. In June 2013, NICE published a new quality standard to improve the quality of care and support for people who self-harm. The Spending Review (2013) committed to every Emergency Department having constant access to mental health professionals and Public Health Outcomes Framework published in (2013) includes the definition of the new indicator on self-harm. This makes clear the priority given to the prevention and management of self-harm across local authority and NHS services.

Evidence Base in Suicide Prevention

The Government published its review of the suicide strategy, *"Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives"* (Department of Health, 2015). This section summaries this, the latest evidence and best practice as identified within the report.

Men and Economic Crisis

A recent study found that men in different age brackets had different suicide risks during the recent recession. Those aged between 35-44 years old experienced increased suicide rates corresponding to economic decline. The study also found the halt in the downward trend in suicide rates amongst men aged 16-34 may have begun before the 2008 economic recession (Coope, et al, 2014).

Self-Harm and Alcohol

There was a higher rate of alcohol-related deaths for those presenting at emergency departments with self-harm for both males and females. Local areas need to ensure that those presenting to hospital with self-harm should be assessed for alcohol problems to identify issues early and get treatment (Bergen, et al, 2014). This is in line with NICE guidelines. In the year following self-harm the risk of suicide is raised 49-fold in the year, this increases with age at initial self-harm (Hawton, et al).

Crisis Resolution

Crisis resolution home treatment services have a key role to play in suicide prevention. Approximately 180 suicides each are patients who are under crisis resolution home treatment services, with approximately 80 among in-patients (Hunt, et al; NCISH 2014).

Primary Care Patients

Both frequent attendance and non-attendance at GP surgeries is linked to increased risk of suicide. For young men, non-attendance is a particular risk factor (NCISH 2002-20012).

Discharge Processes

The first 3 months following discharge from a mental health inpatient episode remains a high risk, with the highest risk at 2 weeks discharge. Community Care reforms which recommend a 7 day follow up have shown positive results although progress has stalled recently (Psychiatry Online).

Self-harm in Prisons

There is an association between self-harm and suicide within the prison setting. Prevention and treatment of self-harm should be part of the suicide prevention efforts within prisons (Hawton, et al, 2014).

National Best Practice in Suicide Prevention

These case studies were reported in, *"Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives"* (Department of Health, 2015).

U Can Cope

The U Can Cope film and online resources were designed for people in distress and those trying to support them, to instil hope, promote appropriate self-help and inform people regarding useful strategies and how they can access help and support. They have been endorsed by the International Association of Suicide Prevention: www.connectingwithpeople.org/ucancope

Social Media

Emerging findings from the research study on Understanding the role of social media in the aftermath of youth suicides (COSMOS), commissioned in support of the suicide prevention strategy, are that:

- Suicidal tweeters show a high degree of reciprocal connectivity (i.e. they follow each other), when compared with other studies of the connectivity of Twitter users, suggesting a community of interest.
- A retweet graph shows that users who post suicidal statements are connected to users who are not, suggesting a potential for information cascade and possibly contagion of suicidal statements.
- The reaction on Twitter to the Hayley Cropper Coronation Street suicide storyline was mostly information/support and debate about the morality of assisted dying, rather than statements of suicidal feelings.
- Tweets about actual youth suicide cases are far more numerous than newspaper reports and far more numerous than tweets about young people dying in road traffic accidents. This suggests that suicide is especially newsworthy in social media. In newspapers there is no significant difference between the two types of death, in terms of number of reports per case.

Nottinghamshire Healthcare NHS Trust and Connecting with People

Nottinghamshire Healthcare NHS Trust is implementing an innovative approach to suicide prevention to improve both patient care and clinical governance. The Trust has developed a team of in-house trainers to deliver suicide and self-harm awareness and response training across the Trust. They are also piloting a web-based App to help to consistently record individual assessments. The App is integrated securely within the NHS system and is based on peer-reviewed clinical tools.

Other Trusts are also involved in the pilot of the App in partnership with the social enterprise *Connecting with People*. The approach being taken:

- Is evidence based and uses peer reviewed clinical tools. It combines compassion with sound clinical governance.

- Is proactive, emphasising safe triage and the co-creation of immediate safety plans for all patients with suicidal thoughts, irrespective of risk. It documents evidence on level of risk and actions agreed to mitigate the risks.
- Has been developed by healthcare practitioners, third sector organisations and service users, for delivery to health and social care practitioners in primary and secondary care and in third sector organisations.

It is an example of how the third sector can work effectively in partnership with the NHS to improve patient care in specialist areas, forming part of the RCPsych OnSite training.

Safety Collaboratives in Mental Health

The South West of England has had a safety collaborative in Mental Health since 2010. This work spread across the South of England in 2013. It involves the majority of Mental Health Trusts in the region. Work streams include getting medicines right, improving physical health care and delivering safe and reliable care. This includes reducing absence without leave from inpatient units and reducing suicides.

North Essex Partnership University NHS Foundation Trust and Samaritans

Three Samaritans branches together with the North Essex Partnership University Foundation Trust have signed a partnership agreement to develop a range of opportunities for patients and staff to benefit from the knowledge, experience and complementary services offered by Samaritans in support of emotional wellbeing and suicide prevention. This will include:

- NHS staff organising for a patient (with their consent) to receive a call from Samaritans.
- Training for non-clinical NHS staff on handling challenging contacts, suicide awareness and emotional well-being.
- Establishing referral pathways between Samaritans and GPs in the area.
- Samaritans presence in Emergency Departments.

This partnership is an example of how the voluntary sector and NHS can deliver better support to people by working together more closely.

Healthtalk Online for parents whose child is self-harming

Drawing on research with families, this website enables parents to see and hear parents and other family members of young people who self-harm share their personal stories on film. The films cover issues such as why young people self-harm, discovering that a young person is self-harming, how they helped their young person, living with self-harm, support and treatment, and what helped them cope. www.healthtalk.org/peoples-experiences/mental-health/self-harm-parents-experiences/topics

Staying safe if you're not sure life's worth living

A new online resource developed by the Royal College of Psychiatrists, Connecting with People, Samaritans, Grassroots Suicide Prevention, State of Mind, leading academics, people with lived experience and their carers.

Staying safe if you're not sure life's worth living includes practical, compassionate advice and many useful links for people in distress:

www.connectingwithpeople.org/StayingSafe .

Local Context

In Berkshire, the trends in suicides broadly reflect the national trends, and the results from the most recent local suicide audit, carried out in 2015, are shown below.

Of note:

- more males completed suicide than females
- 70% of the deaths recorded between 2007-2014 were in age brackets 30-44 and 45-59 years
- The percentage of deaths among the unemployed rose from 13% in 2007 to 38% in 2014
- The most common method for suicide was hanging/strangulation.

Local Suicide Audit Results

During 2015, Public Health Teams in Berkshire undertook an audit of suicide and undetermined deaths during the 2012-2014 period. This audit provides an analysis of the most recent audit and includes comparative data from previous audits. The audit defined suicide as a death where the coroner has given a verdict of suicide (based on evidence that the intent was to cause death or take own life) or where an open verdict was reached in a death from injury or poisoning. The definition comprises suicides and open verdicts coded as ICD10 X60-X84 and Y10-YY34.

Data for the audit was collected from Berkshire Coroner Office case notes for people who died from suicide or undetermined injuries during 2012-2014. The audit only includes Berkshire residents who died in the County. It is important to note that there can be a substantial delay between the date of death and the date of registration for suspected suicides, so it is likely that not all deaths from 2014 were included in this audit.

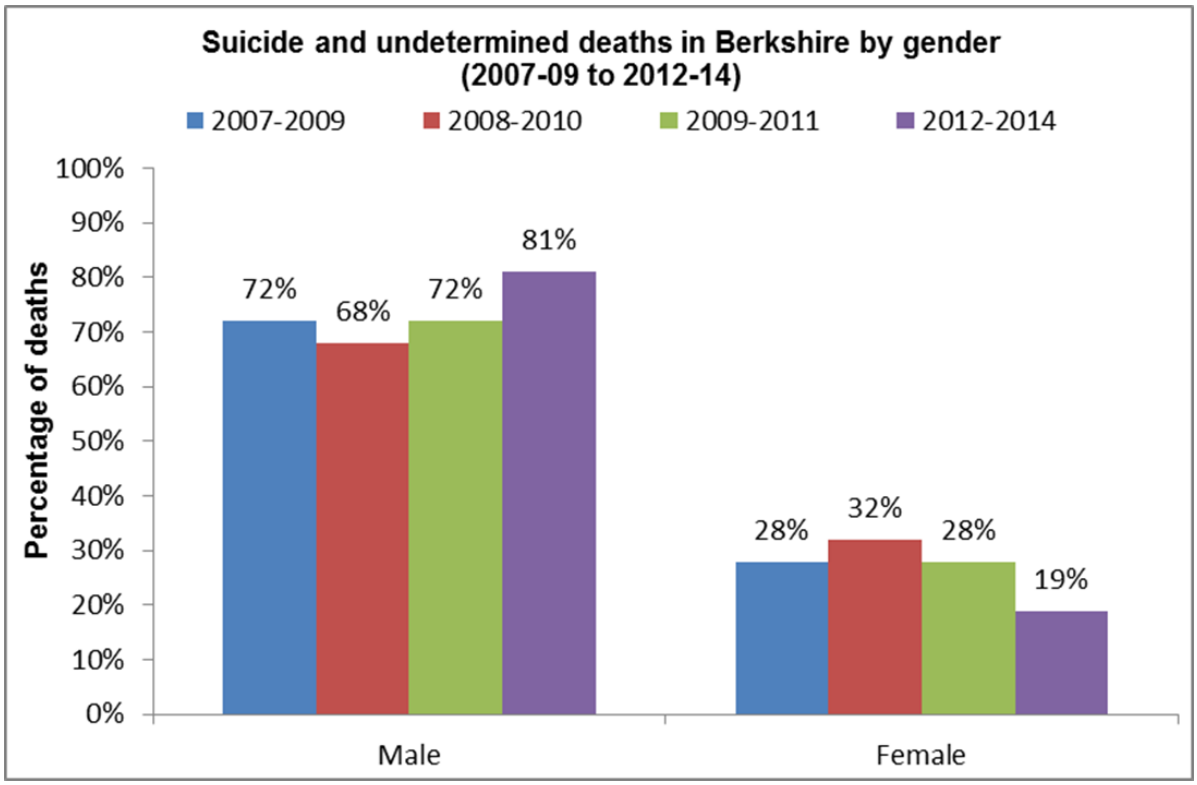
The analysis of suicide data is based on small numbers and is likely to show differences over time or between different groups that are due to random occurrence. However, the analysis of this data can give some indication as to local patterns in suicide deaths. Data from the audit is presented as averages over a three year period to reduce some of the random variations that occur when analysing small numbers. For confidentiality reasons, figures under 5% have been supressed and data is shown at a Berkshire level, rather than by individual local authorities.

120 deaths were included in the Berkshire suicide audit for 2012-14. 70% of these were classified as suicide by the coroner and the other 30% were undetermined deaths / open verdicts.

Gender

Data from all recent audits show that males have a higher suicide rate compared to women in Berkshire. This is consistent with national figures.

Figure 4: Suicide and undetermined deaths in Berkshire by gender (2007-09 to 2012-14)



Age

70% of the deaths recorded in 2012-14 were for people aged 30-59. The audit was carried out using the age brackets as below, and not the age brackets used by the Office for National Statistics (ONS). Future audits will use the ONS brackets to achieve comparison between local data and national data.

Age group	2012-2014
10-19	*
20-29	13%
30-39	23%
40-49	23%
50-59	24%
60-69	*
70-79	*
80-89	7%

Ethnicity

The majority of people dying from suicide or an undetermined death in Berkshire are White-British. This is largely representative of Berkshire's population. In 2011, 73% of Berkshire's population were from a White-British background, ranging from 35% in Slough to 80% in West Berkshire. The majority of deaths from other ethnic groups (Asian/Asian-British and White-Other) were Slough residents and this also reflects the

Borough's population profile. It is important to note that 15% of the cases included in the 2015 audit did not have an ethnic origin recorded in the audit. This is a higher proportion than the previous audit and will therefore have affected the validity of the analysis for 2012-2014 data.

Ethnicity	2007-2009	2008-2010	2009-2011	2012-2014
White-British	77%	75%	77%	61%
White-Other	10%	15%	13%	13%
Asian/Asian-British	<5%	<5%	<5%	12%
Black/Black-British	<5%	<5%	<5%	0%
Not Known	<5%	<5%	<5%	15%

Diurnal and Seasonal Variation

The following tables illustrate the day of the week and seasons in which deaths from suicide occurred in Berkshire during 2007-2011 and 2012-2014.

Day of the week	2007-2009	2008-2010	2009-2011	2012-2014
Monday	19%	21%	21%	20%
Tuesday	16%	17%	17%	13%
Wednesday	16%	11%	10%	9%
Thursday	10%	10%	15%	16%
Friday	8%	9%	7%	14%
Saturday	19%	14%	15%	13%
Sunday	14%	17%	15%	13%

The data shows a relatively even spread across the whole week, with no particularly 'common' day.

Season	2007-2009	2008-2010	2009-2011	2012-2014
Winter (Dec-Feb)	24%	23%	27%	28%
Spring (Mar-May)	29%	30%	27%	31%
Summer (Jun-Aug)	25%	21%	21%	21%
Autumn (Sept-Nov)	21%	26%	28%	18%

Figure 5: Suicide and undetermined deaths in Berkshire by day of week (2007-09 to 2012-14)

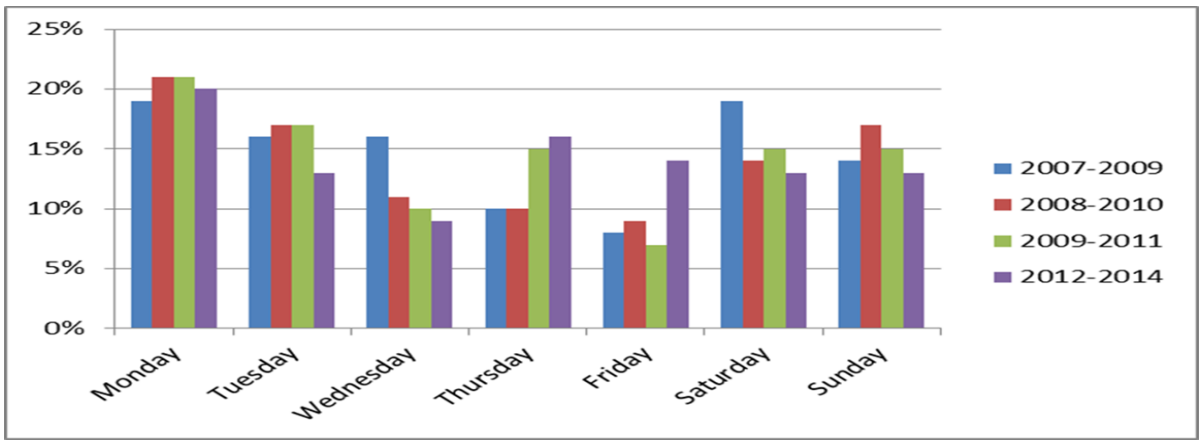
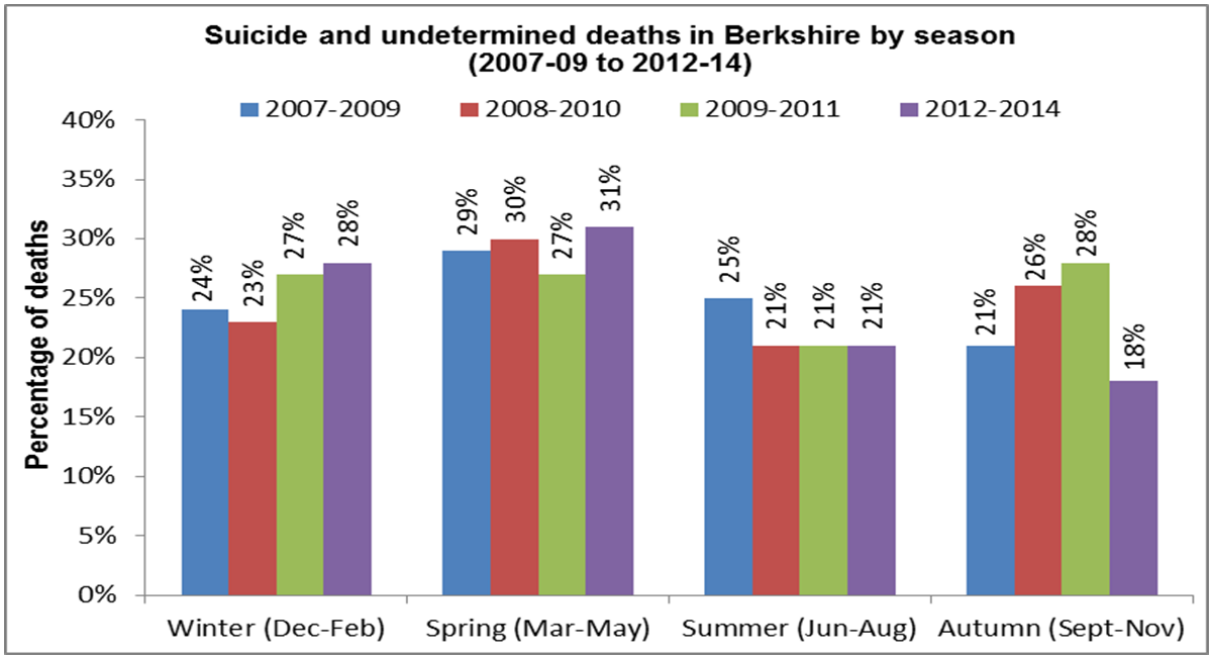


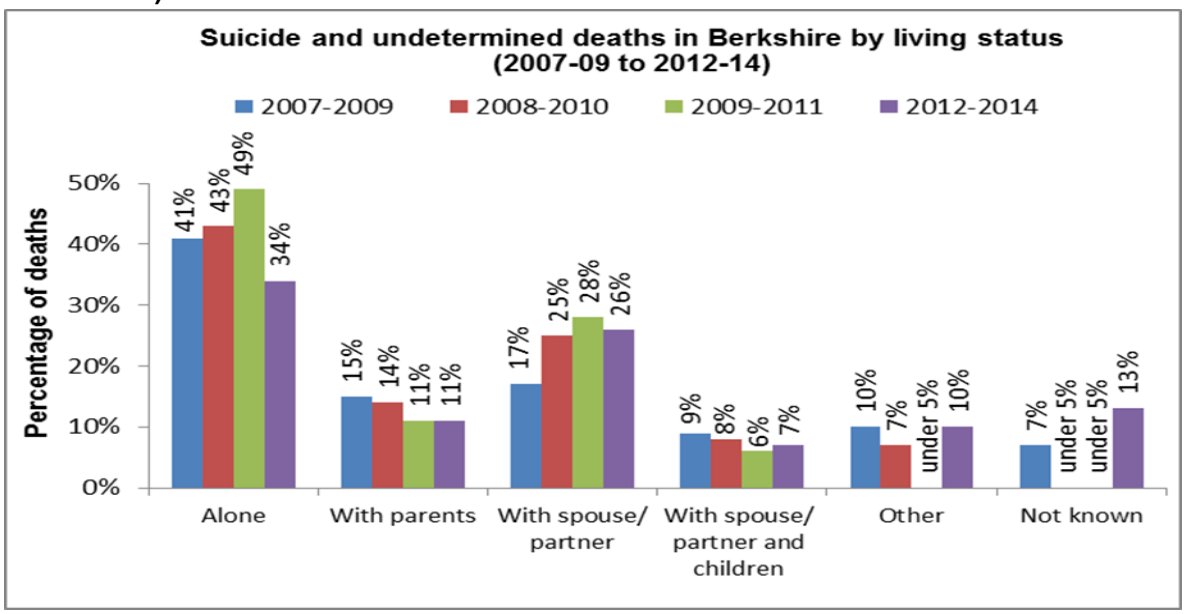
Figure 6: Suicide and undetermined deaths in Berkshire by season (2007-09 to 2012-14)



Marital and Living Status

Recent data from the Office for National Statistics shows that 13% of usual residents in England and Wales were living on their own in 2011. The table below indicates that those living alone in Berkshire are therefore over-represented in suicide deaths. This percentage has reduced from 49% in 2009-2011 to 34% in 2012-2014, however it is still the main living status recorded. It is important to note that the number of people with a living status not recorded or not known is higher in 2012-2014 (13%), which makes comparisons of data difficult.

Figure 7: Suicide and undetermined deaths in Berkshire by living status (2007-09 to 2012-14)



The table below shows that there were more deaths from single people in the two audit periods, ranging from 39% to 45%.

Marital status	2007-2009	2008-2010	2009-2011	2012-2014
Single	45%	39%	39%	40%
Married	23%	29%	30%	29%
Divorced	14%	13%	13%	8%
Separated	10%	7%	7%	<5%
Widowed	4%	6%	7%	<5%
Co-habiting	<5%	<5%	5%	10%
Not stated	<5%	<5%	<5%	6%

Employment Status

Some studies have indicated that there is a strong independent association between suicide and individuals who are unemployed (Lewis and Sloggert, 1998). Unemployment in the Thames Valley is low, although there has been some fluctuation between 2007 and 2014. The lowest level of unemployment during this time was 3.4% in Jul-07 to Jun-08, with the highest rate of 6.1% in Apr-09 to Mar-10.

Data from the 2012-2014 Berkshire audit shows that 38% of people dying from suicide and undetermined deaths were unemployed. This is an over-representation of the population, considering that only 4-5% of people were unemployed during that time period. This is also a notable increase on the figures from 2007-2011, which ranged from 11%-14%. This change may be down to a random occurrence, due to small numbers.

Employment status	2007-2009	2008-2010	2009-2011	2012-2014
Full Time	46%	51%	55%	36%
Part Time	5%	<5%	<5%	<5%
Unemployed	13%	11%	14%	38%
Student	6%	6%	<5%	<5%
Retired	18%	17%	17%	11%
Long-term illness/ disability benefits	<5%	<5%	<5%	<5%
Housewife/husband	<5%	<5%	<5%	<5%
Not known	8%	5%	<5%	12%

Suicide Note

The table below shows the proportion of deaths where a suicide note was left.

Left a suicide note?	2007-2009	2008-2010	2009-2011	2012-2014
Yes	29%	32%	40%	36%
No	71%	68%	60%	54%
Not known	0%	0%	0%	10%

Housing Status

A large number of the cases included in the 2012-2014 audit did not capture the housing status for people, which means that the data cannot be presented in this analysis.

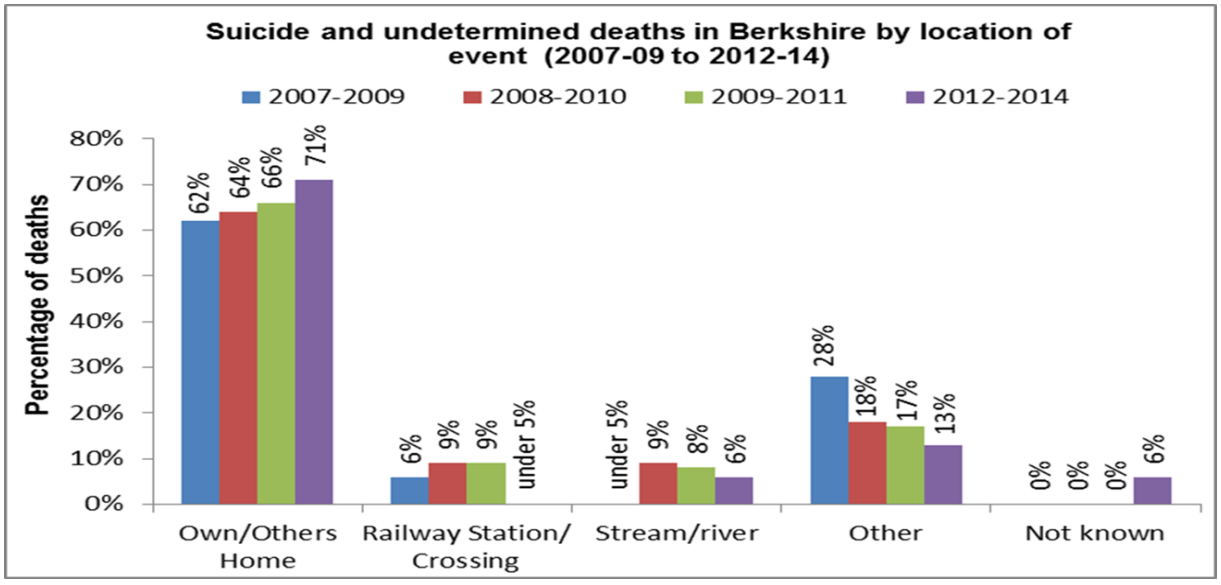
Housing status	2007-2009	2008-2010	2009-2011	2012-2014
Owner/Occupier	46%	46%	52%	35% of these cases did not have a housing status recorded and therefore this data cannot be presented
Privately Renting	41%	33%	25%	
Council House/ Housing Association	5%	9%	11%	
With Parents	<5%	<5%	<5%	
Supervised Hostel	<5%	<5%	<5%	
Unsupervised Hostel	<5%	<5%	<5%	
Other	<5%	<5%	<5%	
Not Known	<5%	<5%	<5%	

Location of event

The majority of deaths identified in the local audits took place in the person's own home or another person's home. This proportion has continued to increase from 62% in 2007-2009 to 71% in 2012-2014.

Location of event	2007-2009	2008-2010	2009-2011	2012-2014
Own/Others Home	62%	64%	66%	71%
Railway Station/ Crossing	6%	9%	9%	<5%
Stream/river	<5%	9%	8%	6%
Other	28%	18%	17%	13%
Not known	0%	0%	0%	6%

Figure 8: Suicide and undetermined deaths in Berkshire by location of event (2007-09 to 2012-14)



Methods Used

Suicide methods can be classified as either ‘active’ or ‘passive’. Active methods are quick and effective allowing little time for reconsideration. Such methods are hanging, shooting, jumping in front of a train or from a height. Among the general population hanging, strangulation and suffocation has been identified as the most common cause of suicide for men. Passive methods are less violent and allow some time for reconsideration or intervention (e.g. self-poisoning, carbon monoxide). Hanging/strangulation has been the most common cause of death over 2007-2014.

Methods used	**2007-2009**	**2008-2010**	**2009-2011**	**2012-2014**
Hanging / Strangulation	54%	47%	48%	49%
Carbon Monoxide Poisoning	8%	<5%	<5%	<5%
Jumping / laying before a train	6%	9%	9%	<5%
Jumping from a height	11%	11%	8%	<5%
Self-Poisoning	10%	9%	12%	0%
Drowning	<5%	7%	7%	6%
Other	7%	12%	14%	38%
Not known	0%	0%	0%	<5%

Alcohol and drugs taken at time of death

The audit of people dying from suicide and undetermined deaths during 2012-14 identified whether alcohol or prescribed drugs were detectable in the deceased. This data was not collected in the previous audit. The tables below show that at least 36% of people who died in 2012-14 had taken alcohol prior to their death and at least 42% had taken prescribed drugs, and outlines those drugs that were implicated in suicide deaths.

Alcohol present?	**2012-2014**	
At intoxicating level	23%	
At non-intoxicating level	13%	
No alcohol detected	54%	
Not known	11%	
Prescribed drugs present?	**2012-2014**	
At fatal level	14%	
At intoxicating level	8%	
At therapeutic level	20%	
No prescribed drugs detected	43%	
Not known	16%	
Drugs implicated	**Male**	**Female**
Antidepressants	✓	✓
Paracetamol	✓	
Coproxomal or similar	✓	✓
Benzodiazepine	✓	
Other hypnotic		
Anti-psychotic	✓	✓

Other substances implicated in suicide deaths in 2012-14 were:

Other substances	Male	Female
Amphetamines	✓	✓
Ecstasy	✓	
Crack/Cocaine	✓	
Ketamine	✓	
Heroin	✓	✓
Opiates	✓	
Methadone	✓	✓

Personal, Social and Health Factors associated with deaths from suicide

The following factors were identified from records at the Coroner's Office as being associated with suicide:

Factor identified	2007-2009	2008-2010	2009-2011	2012-2014
Relationship problems	14%	6%	<5%	29%
Financial problems	9%	6%	<5%	24%
Depression	25%	42%	51%	67%
Low self esteem	<5%	<5%	<5%	Not collected
Other Mental health Issues	8%	8%	<5%	Not collected
Pending Police Investigation	<5%	<5%	<5%	12%
Family bereavement	<5%	<5%	<5%	12%
Physical Health	8%	<5%	<5%	33%
Job related	<5%	<5%	<5%	17%
Not Stated	15%	13%	20%	-

2015 Data Update

The most recent raw data on the number of suicides in Berkshire was released in December 2016 by the Office for National Statistics for the year 2015. This shows an increase across Berkshire as a whole rather than a small decrease as seen in England and the South East. Caution should be employed as these raw data do not give the detail required to indicate trends or draw conclusions.

	2014	2015	Difference
Bracknell Forest	5	10	+ 5 (+ 100%)
RBWM	11	11	0
Slough	15	9	- 6 (- 40%)
Reading	12	18	+ 6 (+ 50%)
West Berkshire	5	6	+ 1 (+ 20%)
Wokingham Action	6	14	+ 8 (+ 233%)
Berkshire Total	54	68	+ 14 (+126%)
SE England Total	794	756	- 5%
England Total	4882	4820	- 1%

Local Governance Structures

In order to facilitate the production of this strategy and to steer the Berkshire-wide audit of suicides, a strategic group was convened with representatives from organisations across county. This worked under the identity of the Berkshire Suicide Risk & Self Harm Reduction / Prevention Steering Group. During 2015/16 as key staff changed, the group has lost some of its membership and had become less strategic. The original terms of reference state that the group:

> "*will provide public health leadership and advice to support a joint approach to achieve real change in the prevention of suicides and self- harm through actions taken by member organisations. It will facilitate the bringing together of clinicians, professionals and organisations, with the patient's voice, to deliver surveillance data to support projects / programmes to prevent suicides and offer support to those who are bereaved*."

Public Health England (2016) suggests that the membership of suicide prevention partnerships is made up of representative working with adults, children and young people. The following diagram suggests the range of partners who may be included.

The Berkshire Steering Group will need to own this strategy, and the membership should be updated to ensure a closer fit with the groups suggested above. The membership of the current group as at December 2016 is detailed in Appendix 8.

RECOMMENDATION

That the Berkshire Steering Group re-visits their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.

There are other groups for whom this strategy and its action plans are an important issue, and these include commissioning boards in the East Berkshire and West Berkshire Confederations of CCGs; Health and Wellbeing Boards; Health Overview and Scrutiny Committees; Adult Safeguarding Boards; and Community Safety Partnerships. In order to get full endorsement of this strategy and for organisations to commit to their action plans, the terms of reference should ensure that the links to these other structures are robust and transparent.

Members of the Steering Group could be asked to act as suicide prevention champions. These are individuals who get involved in specific pieces of suicide prevention work – and might include people who have been bereaved by suicide or those with a special interest or expertise. They can be pivotal in raising issues regarding suicide awareness locally, and drive forward the action plans of their agencies. A specific initiative to engage the elected members of councils as Mental Health Champions may provide an opportunity for them to also speak out on suicide prevention. Details of this initiative are available here: http://www.mentalhealthchallenge.org.uk/the-challenge/

RECOMMENDATION
That organisations represented on the Berkshire Suicide Prevention Steering Group consider nominating a suicide prevention champion from within their membership.

Monitoring & Evaluation and Progress

This is a pan-Berkshire and multi-agency Strategy and the action plans for this strategy which are overseen by the Berkshire Suicide Prevention Steering Group are set out below.

Individual Borough action plans for each of the six Berkshire Unitary Authorities are also included and are set out in appendices 2-7. These give a more local set of priorities and respond to the particular geographical issues, population structures and general health needs of the Authorities.

Other agencies which are part of the Steering Group may have their own action plans and an objective of this strategy is to bring these into one combined action plan as far as possible and to share openly the actions plans of all agencies in order to learn from one another; to avoid un-necessary duplication of effort or resources; and to encourage co-production of outcomes.

Links to Other Local Strategies

This is the first comprehensive Berkshire-Wide Suicide Prevention Strategy and action plans have been produced for the year 2017-18. One of the objectives is to ensure that this strategy, its aims and objectives are shared and upheld in the strategies, action plans and objectives of all those groups across Berkshire who are committed to improving health outcomes, promoting wellbeing, removing the stigma associated with mental health and preventing suicides.

Local Joint Health and Wellbeing Strategies and their action plans should endorse this Strategy and Health and Wellbeing Boards are key to the governance of this Strategy and the Steering Group. Through tightly-knit joined up thinking, organisations, individual and communities across Berkshire can come together to make the progress necessary to reduce suicides in our populations.

RECOMMENDATION

That all agencies represented on the Steering Group commit to an annual Action Plan of their own which can then be brought together to create a Berkshire-wide Action Plan for each year of the Strategy.

Local Best Practice in Suicide Prevention

Thames Valley Suicide Prevention and Intervention Network (SPIN) CALMzone

The Campaign Against Living Miserably (CALM) was originally a Department of Health helpline project on suicide prevention particularly targeting younger men using marketing methodology and images to specifically engage with this audience on issues surrounding mental distress and social alienation. The resources produced directed men to a special helpline, and latterly to web-based resources. In 2000, a partnership of six areas in the North-west of England commissioned this work for young men in Merseyside, which continued when CALM transferred into a national charity. There is a local CALMzone Coordinator who promotes CALM across Merseyside in collaboration with the local community – pubs and clubs, venues and universities, sports teams and clubs – to encourage them to join and promote the campaign.

In 2015, the local authorities across the Thames Valley through SPIN funded a Thames Valley CALMzone, and employed a coordinator undertaking similar promotions as in Merseyside. CALM have provided local commissioners with anonymised reports on numbers and trends of calls and web chats across the Thames Valley. As well as providing funding to support the helpline, the commissioners ensure CALM has an up-to-date local database of agencies which local callers can be referred to. Berkshire local authorities have continued to fund the helpline until June 2017, although the local coordinator post is no longer funded.

RECOMMENDATION
Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

Real Time Suicide (and near fatal self-harm) Surveillance

It is important to have a real time overview of self-inflicted deaths/suspected suicides and near fatal self-harm in order to provide timely support for those bereaved and affected, pick up community risks of contagion or suicide clusters and identify public places where suicides/incidents of near fatal self-harm appear to occur with increasing frequency. All of these activities contribute to suicide reduction and prevention in line with national and local strategy. Thames Valley Police (TVP) and the Thames Valley Suicide Prevention and Intervention Network (SPIN), supported by funding from the Thames Valley Strategic Clinical Network are collaborating to build on the supportive signposting for people bereaved by suicide work and develop a robust real time surveillance process.

In simple terms this process is as follows:

- TVP identifies and collates suspected suicides on the Gen 19 sudden death form.
- Coroner's officers send Gen 19s of suspected suicides to a central TVP email for monitoring.
- Details of the incidents in real time are thereby collated and are available for analysis, reporting and provide the ability to respond.

- Details of families who consent to 'Supportive Signposting' are sent to a central NHS England suicide bereavement address.
- Supportive literature and referral signposting links to organisations and charities are provided to relatives.

RECOMMENDATION
Ensure bereavement information and access to support is available to those bereaved by suicide, including professionals involved in the case.

Further data is being collated from the following sources;

- NHS England monitor the strategic executive information system database for suspected suicides and near fatal self-harm.
- Links are being established with British Transport Police to monitor suspected suicides and near fatal attempts on the railways
- Links are being established with prisons to monitor prison suspected suicides and near fatal attempts.
- Links are to be established with the general hospital psychiatric liaison services to monitor incidents of near fatal self-harm.

All of this information will be reviewed by the TVP and SPIN leads and figures and concerns will be communicated to local public health suicide prevention leads for consideration within the local multi-agency suicide prevention action groups. A hub of SPIN comprising TVP, public health, NHS and the University of Oxford Department of Psychiatry Centre for Suicide Research has been established to maintain oversight of the regional prevalence of suicide with the aim of collaborating where indicated, in order to respond to issues that concern the whole geography, for example contagion and clusters.

Berkshire Healthcare Foundation NHS Trust (BHFT) Zero Suicide Programme

Berkshire Health Care Foundation NHS Trust have been inspired by the pioneering zero suicide approach within the Henry Ford Hospital System (USA). The Henry Ford Hospital System managed to implement a philosophy and practice of 'perfect depression care' which led within four years to a 75% drop in suicides, and eventually to years without a single suicide. For BHFT Zero suicide means using the ambitious target of zero to help focus on this quality improvement issue. Thinking in this way encourages tracking of best practices and formally incorporating them into how service users are treated. Most importantly, it encourages Trust staff to work with in collaboration with service users, carers and primary care colleagues to focus on genuine service user engagement and identification of need.

Based on their analysis of research and Trust data showing key patterns and risk points for suicide, BHFT have set key priority areas for their zero suicide campaign.

1. Optimise systems to enable staff to focus on engagement and collaborative approaches to risk assessment and management with service users and carers at the centre.

2. Training and supervision to equip staff with skills and competence to practice recovery focussed approaches to suicide risk and enable positive risk management and safety planning.
3. Development of a BHFT suicide surveillance dashboard – real time information on service gaps and analysis of patterns to inform practice and training.
4. Collaborating with colleagues, service users and carers as part of a wider suicide awareness campaign beyond secondary mental health care.

Royal Berkshire NHS Foundation Trust (RBFT) Zero Suicide Programme

Royal Berkshire NHS Foundation Trust is working in partnership with BHFT services, Thames Valley Police and Samaritans (Reading) to support the BHFT's ambitious target of zero suicide.

Based on their analysis of research, Trust data showing key patterns and risk points for suicide and patient, family and carer experience RBFT have set priorities for their zero suicide plan which is driven and monitored through a multiagency Suicide and Self Harm Prevention Governance Group chaired by their Mental Health Coordinator related to:

1. Collaborative working with the Psychological Medicine Service (PMS) and patient families and carers to risk assess individuals who attend in crisis

2. Environment, Estate and capacity of teams

3. Training, supervision and support to provide staff with skills and competence to recognise risk and mange it proactively in partnership

4. Collaborative working with multiagency colleagues, patients, families and carers and our staff as part of a wider 'Let's Talk Mental Health' campaign.

Areas of High Frequency

Due to their geography, design or operational use, there are places which present easier access to the means of suicide than others. This could be as a result of their isolation from staff operating their functions; because they are more generally isolated from crowds and the general public: or because life-threatening hazards exist which are generally mitigated by normal operation. They may have become known as places where suicides have occurred previously, either via media reports, or word of mouth.

The Railway Network

The railway network, mostly operated by Network Rail, is in places associated with higher frequencies of suicides, injurious attempts at suicide and suicide attempts and other incidents of people in hazardous positions which do not cause physical injury. The rail network in Berkshire includes a section of the main Great Western Railway routes from London to Wales and the South West, as well as sections of suburban rail lines and minor branch lines. The Great Western lines feature high-speed trains, and is presently being electrified by means of overhead cables. Most of the suburban rail lines are electrified using a third rail system. As well as a high volume of passenger trains, most local lines also feature freight trains operating throughout the day and night.

On average there are 255 suicides on the network per annum. Rail staff particularly drivers, are likely to be severely traumatised by these events and some may never return to work and therefore might need to access support services because of that. Network Rail operates a comprehensive programme of suicide prevention, working to reduce the potential for suicides to occur on the rail network and the industry sees its potential as going beyond that by seeking to do all it can to prevent suicides in its neighbouring communities. In 2015 Network Rail, together with British Transport Police, and Samaritans agreed a process whereby any location that experienced three suspected suicide or injurious attempt incidents (or a combination of the two) would be subject of an escalation process. This would mean that enhanced working would be taken by all three parties in order to prevent further incidents at that that location. In Berkshire, there are locations where this process has been enacted. Actions taken at these locations include engineering solutions, such as the replacement of crossing with overbridges; or the fencing off of platforms on non-stopping fast lines; and the placement of Samaritans posters across the location.

RECOMMENDATION
That local authority public health teams take the leadership for liaison with any "Escalation Process" in their area, and report on progress to the Steering Group.

The Motorway and Roads Network

Most motorways and trunk roads (the strategic road network) are the operational responsibility of Highways England, with most other roads being the responsibility of local authorities, whilst some roads and byways are in private ownership. In Berkshire, the main London to South Wales Motorway, the M4 passes through the length of the county through all of the six unitary authorities and is managed by Highways England,

whilst the adjoining A329(M) motorway is the responsibility of Wokingham Borough Council. The speed of traffic on these roads and other major roads together with their overbridges provide places which can give access to the means of suicide. In 2013, the Highways Agency Traffic Officer Service attended 293 of 652 suicide/attempted suicide incidents on the strategic road network. Between April 2013 and December 2014, there were over 1,500 incidents which were brought to the attention of a Traffic Officer (Sutherland, 2015). Definitions in this area are not clear, but this does seem to indicate an increase in the reporting of road network incidents, if not in the number of incidents themselves.

RECOMMENDATION
That the Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

Car Parks and Tall Buildings

Berkshire towns feature a number of multi-storey car parks of which some in the management or ownership of the Local Authorities. There are also many other tall buildings both residential and commercial, and together these locations can sometimes provide an access route to a means of jumping from a height.

The Horsham branch of Samaritans is working with a local shopping centre and car park where suicides have occurred. They offer sessions for the car park attendants who are generally the first on the scene. They also have an arrangement with the shopping centre to call Samaritans if there is an incident, either to support the staff involved or to support shoppers/shop workers more generally if the incident was widely witnessed. (Sutherland, 2015). This is a simple intervention in which suicide prevention training could be incorporated.

Local Authority Settings

Local authorities may be responsible as owners, operators or managers of other facilities and locations where suicides may take place. This may be because of their isolation or due to their inclusion of specific means of suicide within them. Generally the local authorities in Berkshire look after many hectares of open space; parkland; and woodland, some of which may be managed as part of the highways network; but with most likely to be part of an open spaces portfolio. There is also significant waterside public realm managed or owned by the authorities. The risks at these sites include strong, tall trees as a means of hanging; access to water features such as lakes, rivers and canals which pose a risk of drowning; and dense undergrowth which could allow a person to die through neglect and exposure. Council staff and contractors may have an enhanced role to play in identifying suicide risks and in supporting people who appear to be in distress

RECOMMENDATION
That local authority public health teams work with other council departments such as car parks and open space services to identify local actions to prevent suicide including staff awareness training.

Mental Health Crisis Care Concordat

The Mental Health Crisis Care Concordat is a national agreement between 22 national agencies involved in the care and support of people in crisis and includes health, policing, social care, housing, local government and the third sector. It sets out how these agencies will work together better to make sure that people get the help they need when they are having a mental health crisis. Local areas have submitted declarations and developed action plans for the improvement of local mental health crisis care for their areas.

The Concordat focuses on four main areas:

- Access to support before crisis point – making sure people with mental health problems can access help 24 hours a day and are taken seriously.
- Urgent and emergency access to crisis care – making sure that a mental health crisis is treated with the same urgency as a physical health emergency.
- Quality of treatment and care when in crisis – people are treated with dignity and respect, in a therapeutic environment.
- Recovery and staying well – preventing future crises by ensuring that people are referred to appropriate services.

Although the Crisis Care Concordat focuses on the responses to acute mental health crises, it also includes a section on prevention and intervention. This strategy includes and reflects some of the key messages and recommendations from the concordat, aiming to reinforce a commitment by partners to work together in preventing and managing crises.

The local Crisis Care Concordat has, common to this strategy, been set at Berkshire-wide level, and has a comprehensive action plan, and certain actions include specific suicide prevention actions. These relate to the work of British Transport Police and the escalation process and staff training issues. They are more detailed than the recommendations and actions set out in this strategy, but there is strategic fit. There is a need to ensure full reference to this strategy in the Crisis Care Concordat action plans, and for further synergies to be explored.

RECOMMENDATION
Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.

Gap Analysis and Emergent Berkshire-Wide Concerns

A gap analysis was undertaken by members of the Steering Group to identify the areas of the National Strategy which were not seen to be adequately addressed across Berkshire, taking into account the results of the local Suicide audit and the demography of the six unitary authorities. Some emergent concerns have also been captured which reflect discussion on the audit findings.

High Risk Groups

This strategy recognises that individuals may fall into two or more high-risk groups. Conversely, not all individuals in the group will be vulnerable to suicide. Other risk factors, such as loneliness, social circumstances and physical illness, must also be considered within the wider context or risk (Preventing suicide in England, Department of Health, 2012).

Berkshire is home to the University of Reading and other higher and further education establishments. Although the risk of suicide in the student population locally has not been established, recent ONS data (ONS, 2012) has shown a substantial increase nationally in both male and female suicides in the student population from 2007-2011.

Carers and people with long-term conditions have been highlighted as a local population at particular risk and this has been reinforced by the investigations into domestic homicides where a partner had subsequently taken their own life or attempted to. Adult Social Care and Public Health Outcomes Frameworks record measures of carer social interaction and that of people receiving care which give an insight into the vulnerabilities of these groups, and these are highlighted in the PHE Suicide Prevention Profiles. Not all people with a long-term health condition will be captured within these data, however; and the impact of symptoms such as chronic pain and reduced mobility, and access to certain medicines make this a group with heightened risk and access to means of suicide.

Berkshire no longer contains a prison. People in the criminal justice system will be imprisoned in neighbouring counties, which could make access visits more difficult for family and friends leading to increased isolation for the imprisoned.

Self-Harm continues to be an important risk factor for suicide and growing evidence to support using self-harm as an outcome measure for suicide prevention work with evidence showing that hospital presentation following self-harm is a clear risk factor for suicide (Hawton et al. 2012). There are around 200,000 episodes of self-harm that present to hospital services each year in England, although the true scale of the problem is not known as many people who self-harm do not attend A&E, or seek help from health or other services. Around 50% of people who die by suicide had a history of self-harm, in many cases with an episode shortly before their death, and around 15% of those who die by suicide have carried out an act of self-harm leading to presentation at hospital in the year before their death (PHE 2016).

The table below shows the rates of self-harm and suicide in the six authorities in Berkshire from the PHE Suicide Prevention Profiles (PHE, 2016A). All authorities have lower rates than England, although there is quite some variation across the authorities. It is important to ensure implementation of the NICE standards and pathways CG16 and CG133 for managing patients who self-harm.

Indicator	Period	England	SE England	Bracknell Forest	Reading	Slough	West Berkshire	Windsor & Maidenhead	Wokingham
Hospital stays for Self-Harm	2014-15	191.4	193.1	118.3	130.0	162.2	127.0	150.6	91.1
Suicide Rate persons	2013-15	10.1	10.2	8.1	11.0	8.8	7.0	7.1	6.0
Suicide rate (male)	2013-15	15.8	15.9	*	19.0	14.8	*	*	*
Suicide rate (female)	2013-15	4.7	4.8	*	*	*	*	*	*

Source: PHE Prevention Profiles. 2016

RECOMMENDATION
Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

Tailor approaches to improve mental health in specific groups

Work on detailed Mental Health Strategies is underway across the Berkshire East and Berkshire West health systems. It will be important to ensure a good strategic fit between this strategy and those that are developed. Mental health and wellbeing promotion will remain important objectives of both strategies.

RECOMMENDATION
Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

Support research, data collection and monitoring

With real-time surveillance giving information on suicides and many near fatal self-harm events, there is concern that not all events will be recorded, for instance those attempted suicides which occur on the highways network.

There is further analysis of Coroner's case notes that is recommended as good practice, such as the last contact with a GP which have not been captured in the last local audit. A new audit should be run with this new category for deaths in the period 2014-16, beginning as soon as practicable. This can then be appraised alongside data received through real-time surveillance; gaps identified and protocols and policies put in place to

ensure that data can be confidentially shared for the purposes of identifying trends and clusters in order to take appropriate preventative actions.

RECOMMENDATION

Develop working relationships between individual coroners and local public health teams ensure local plans are evidence based and responsive. Coroners can be invited to become formal members of any local suicide prevention groups or networks

Coroners can also inform the local authority or Director of Public Health if they identify particular areas of concern, e.g. locations used for suicide, possible clusters of suicide, increase in a particular method or new and emerging method of suicide.

Refresh the Berkshire-wide Suicide Audit for deaths in the period 2014-16 to include new categories based on best practice.

Domestic Homicide Reviews

Domestic Homicide Reviews (DHRs) are part of the Domestic Violence, Crime and Victims Act 2004 and became law as of the 13th of April 2011. They do not replace but are in addition to an inquest or any other form of inquiry.

DHRs are one way to improve responses to domestic violence and aim to prevent the avoidable death of a member of the community. The review helps to ensure that public bodies including health, local authorities, police and other community based organisations understand the factors surrounding the death and identify where responses to the situation could have been improved. From this, the agencies involved are in a stronger position to learn appropriate lessons, including those involving joint working. A DHR does not seek to lay blame but to consider what happened and what could have been done differently. It also recommends actions to improve responses to domestic violence situations in the future.

DHRs are commissioned by Community Safety Partnerships where a death of a resident has occurred in accordance with the criteria set out in the Home Office Multi Agency guidance;

> ‘Domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:
> (a) A person to whom he was related or with whom he was or had been in an (a) intimate personal relationship, or
> (b) A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.’

Updated DHR guidance was published in December 2016 and the DHR process is also now available to cover historic victims of domestic abuse:

> “Where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in

the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable."

Such circumstances are likely to be rare; however the duty to undertake a DHR if required may place additional burden on those implementing suicide prevention locally. However, this must be balanced with the likelihood of new learning, which should be fed back into the Berkshire Suicide audit process.

Berkshire-Wide Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:	Delivery Lead
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017	Lead Consultant Mental Health
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017	Local PH Mental Health Leads
		Launch of strategy at multi-agency suicide prevention summit.	15 Oct. 2017	Strategic DPH
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 Oct. 2017	Local PH Mental Health Leads
		Develop Berkshire-wide information sharing protocols to best utilise real time surveillance of suicides and near misses, in order to respond promptly to local trends and risks to reduce risk of clusters, and inform future service delivery.	30 July 2017	Lead Consultant Mental Health
		The Steering Group revisit their terms of reference and membership and become known as the "Berkshire Suicide Prevention Steering Group", with the aim of providing the governance to this strategy and its action plans.	1 April 2017	Steering Group Members
		Ensure strategic fit with the action plans of the Berkshire Crisis Care Concordat.	1 April 2017	Lead Consultant Mental Health
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Men	Evaluate the Berkshire-Wide CALMzone initiative and agree Berkshire-wide commissioning of specific support services for men for future years. To include future commissioning of CALMzone for younger men; and services for middle aged men and older men.	15 Oct. 2017	Lead Consultant Mental Health
	People who self-harm	Ensure agencies have plans to Implement the NICE guidelines on self-harm	15 Oct. 2017	Lead Consultant Mental Health
	People who misuse substances	Ensure local strategies and contracts for DAAT services include suicide prevention objectives.	Ongoing work	Local PH Mental Health Leads

	People in mental health care	Support BHFT in its Zero Suicide Approach, and support local prevention work across the care system.	Ongoing work	Steering Group Members
	People in contact with the criminal justice system	Identify local actions to prevent suicide in those in contact with the criminal justice system, recognising increased incidence of self-harm in the prison population.	30 July 2017	Local PH Mental Health Leads
	Occupational groups	Ensure local health trusts and providers can demonstrate actions to prevent suicide and promote mental wellbeing amongst their staff.	30 July 2017	Steering Group Members
		Identify particular local action plans for those in agricultural / land-based industries.	30 July 2017	Local PH Mental Health Leads
2. Tailor approaches to improve mental health in specific groups	Community based approaches	For the Steering Group to assess community-based interventions which may be best delivered at scale across the county.	Ongoing work	Steering Group Members
	Suicide prevention training	Coordinate a database on evidence based suicide prevention training programmes and providers across the county.	Ongoing work	Steering Group Members
	People vulnerable due to economic circumstances	For the Steering Group to solicit data from each LA on key indicators that may highlight risk: e.g. number of homelessness presentations.	Ongoing work	Steering Group Members
	Pregnant women and those who have given birth in last year	To undertake a needs assessment of this group in relation to suicide prevention.	30 July 2017	Local PH Mental Health Leads
	Children and young people	Through LSCBs, identify local actions to prevent suicide in children and young people.	30 July 2017	Local PH Mental Health Leads
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and Samaritans with local escalation process locations and general suicide prevention work.	Ongoing work	Steering Group Members
		Investigate suicides on council owned land and properties, and agree a local action plan.	15 Oct. 2017	Local PH Mental Health Leads
		Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work	Local PH Mental Health Leads

		The Steering Group seek a named Highways England officer to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.	1 April 2017	Lead Consultant Mental Health
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources), and support services such as SOBS (Survivors of Bereavement by Suicide).	Ongoing work	Steering Group Members
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept 2017 1 April 2017	Lead Consultant Mental Health Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads Local PH Mental Health Leads
6. Support research, data collection and monitoring		Refresh Berkshire-wide suicide audit to include deaths during 2014-2016 to include data on GP consultations. To update data on the JSNA summary on suicide.	30 July 2017 As per JSNA timetable	Local PH Mental Health Leads Local PH Mental Health Leads

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To be checked and formatted

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Appendix 1: Resources available

These need checking and additions

Factsheet on managing suicide risk in Primary Care
http://www.connectingwithpeople.org/sites/default/files/SuicideMitigationInPrimaryCareFactsheet_0612.pdf

A free booklet on debt advice is available from:
http://www.moneysavingexpert.com/credit-cards/mental-health-guide#collect

Guide for health and social care workers to support people with debt and mental health problems written by the Royal College of Psychiatrists and Rethink Mental Illness:
http://www.rcpsych.ac.uk/pdf/FinalDemandcf.pdf

Primary Care Guidance on Debt and Mental Health from the Royal College of GPs and Royal College of Psychiatrists, due to be updated shortly:
http://www.rcgp.org.uk/clinical/clinical-resources/~/media/Files/CIRC/Mental%20health%20forum/Mental%20Health%20Page%20Sept%202013/PCMHF-Guidance-Debt-Mental-Health-Factsheet-2009.ashx

Leeds Bereavement Forum has produced a short document with details of local and national support services available.
http://www.leeds.gov.uk/docs/Bereavement%20leaflet%202013.pdf

Grassroots Suicide Prevention Brighton & Hove Suicide Prevention Strategy Group provides an excellent website full of practical suicide prevention expertise.
http://prevent-suicide.org.uk/suicide_safer_brighton_and_hove.html

RAID service saves money as well as improving the health and well-being of its patients.
http://www.bsmhft.nhs.uk/our-services/rapid-assessment-interface-and-discharge-raid/

NHS Cornwall and Isles of Scilly, in partnership with Outlook South West
http://www.outlooksw.co.uk/suicide-liaison-service

Children and Young People's Mental Health Coalition Resilience and Results:
http://www.cypmhc.org.uk/resources/resilience_results/

State of Mind is a Rugby League mental health and wellbeing initiative which aims to raise awareness and tackle stigma. The organisation aims to reach men who may not normally contact health and social care services, and signpost them to where support is available. A round of Rugby League fixtures is dedicated to State of Mind, which maximises the publicity. The focus is on promoting player welfare and resilience in local communities. Super League players act as ambassadors reaching fans and amateur players through presentations, meetings and social networking, with positive messages being specially commissioned and tweeted. Films with specific themes are available at www.stateofmindrugby.com

Samaritans Media Reporting Guidance:
http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide

Appendix 2: Bracknell Forest Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People in mental health care Occupational Groups Carers (including young carers) Socially isolated	Promotion of CALM to a wider audience Support BHFT in its Zero Suicide Approach Work with local Carers' support groups to highlight Mental Wellbeing issues and risk factors Multi agencies approach to identify individuals and sign posting for support/ local befriending service/ other services Increase local befriender 's awareness of Mental Wellbeing issues and Risk factors	1 June 2017 Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches People vulnerable due to economic circumstances	Work with local Domestic Abuse Forum and Executive Group to provide support and information on suicide prevention To share local Suicide Prevention strategy/action plans/supporting materials with IAPT/Job Centre and other employment support agencies Increase agencies awareness of Mental Wellbeing issues and Risk factors	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources).	Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 3: Royal Borough of Windsor and Maidenhead Action Plan 2017-18

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Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale/lead	Delivery Lead
Overarching Aims		Establish a multi-agency steering group: terms of reference to be agreed. Group will also be responsible for reviewing communication between primary and secondary care including risk assessment and escalation protocols	Locally determined	To be locally determined
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Priority groups for 17/18: men; carers; unemployed; those who misuse substances; and those with mental health diagnoses.	Build on existing local voluntary and community group programmes e.g. men in sheds. Training for gatekeepers relating to priority at-risk groups (Warwickshire). Support BHFT in its Zero Suicide Approach Ensure adequate arrangements are in place for follow-up after discharge from secondary care Consider strengths and issues arising from the Berkshire crisis concordat relating to the Royal Borough of Windsor and Maidenhead.	Ongoing work Locally determined Ongoing work Ongoing work Ongoing work	To be locally determined
2. Tailor approaches to improve mental health in specific groups	Suicide prevention training	Map evidence of coverage by sector/organisation of self-harm and suicide prevention training.	Ongoing work	To be locally determined
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and	Ongoing work 15 Oct. 2017 Ongoing work	To be locally determined

		take appropriate action(s) e.g. work with local media.		
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources). Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide. Map existing bereavement support and pathways.	Ongoing work Locally determined Ongoing work	
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide.	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017	

6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Develop a suicide audit database (based on Bromley model) and continue to update relevant local data from sources which include: Office for National Statistics, Coroner's records, Thames Valley Police Work with steering group members to review data about current levels of population need and service provision Work with steering group members to map areas of high risk through information on locations of deaths and attempts. Take action to reduce suicide enablers (e.g. install signage, barriers) in line with evidence base Undertake mapping relating to local suicide prevention and self-harm services.	As per JSNA timetable Locally determined Locally determined Locally determined Locally determined	

Appendix 4: Slough Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	1 April 2017 1 April 2017 15 Oct. 2017 15 Oct. 2017
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People who misuse substances People in	Promotion of CALM to a wider audience To partner with the drugs and alcohol team on reviewing the referral pathway for dual diagnosis. To continue to ensure that information on how to access DAAT services and seek help are readily available for young men. Support BHFT in its Zero Suicide	Locally determined

	mental health care Occupational Groups	Approach To support SME business on the Slough Trading Estate on incorporating mental health and wellbeing in their policies and advise on how to improve staff well-being; i.e.; promote resilience training	Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training People vulnerable due to economic circumstances Children and young people	To work with the community development team – to continue to build community cohesion, etc. To identify and work with Housing and unemployment teams on MHFA training for staff To deliver MHFA training to managers of SME businesses in Slough To partner with NEET young people's team and train staff on MHFA To design a service information leaflet for new migrant arrivals and to ensure that all frontline services have an access to the leaflet. To partner with young people service to design an intergenerational programme addressing loneliness and social isolation	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) To conduct a mapping of services available for those that have been bereaved by suicide Contact Samaritans SBCCG in order to identify Slough residents assessing the service and where they refer them to Contact the community mental health team to ensure all frontline staff have the information required to signpost patients to bereavement services	Ongoing work Locally determined

		To identify other local stakeholders and provide better information and support to those bereaved or affected by suicide	
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable

Appendix 5: Reading Action Plan 2017-18

What will be done – the task	Who will do it	By when	Outcome – the difference it will make	Supporting national indicators
Identify local sponsors to oversee Reading's Suicide Prevention Action Plan	Health & Wellbeing Board (Berkshire West Mental Health Strategy Group / Reading Mental Health Strategy Group)	February 2017	Reading actions to reduce deaths by suicide will be co-ordinated across agencies / There will be consistent local representation on the Berkshire Suicide Prevention Planning Group	
Develop a communication plan to raise awareness of Reading's Suicide Prevention Action Plan, including: - the formal launch of the Berkshire Suicide Prevention Strategy - contributions to the 'Brighter Berkshire' Year of Mental Health 2017 - marking World Suicide Prevention Day (10 September)	RBC Communications Team	April 2017	Individuals will have increased awareness of support available / Partners will know how to engage with and support the Reading Suicide Prevention Action Plan	
- Support the review of CALMzone and development of future commissioning plans for support services which target men - Review local DAAT contracts to ensure suicide prevention objectives are included - Develop post discharge support for people who have used mental health services via the Reading Recovery College	Wellbeing Team, RBC	October 2017 April 2017 Ongoing	Suicide risk will be mitigated for higher risk groups: men, people who abuse drugs or alcohol, people who have been in contact with mental health services	PHOF 4.10 – suicide rates
Tailor approaches to improve mental health in specific groups: - Support delivery of the local 'Future in Mind' programme to improve mental health in children and young people - Recognise the mental health needs of survivors and links to suicide prevention in the implementation of the Reading Domestic Abuse Strategy - Raise awareness of support available to	Local sponsors (see above) DENS, RBC Local sponsors (see above) Local sponsors (see above)	Ongoing tbc ongoing	Mental health will be improved for some specific groups (children and young people, survivors of domestic or sexual abuse) through tailored approaches Future commissioning of	See Action Plan for Priority 4 for details.

survivors of sexual abuse through Trust House Reading - Contribute to a Berkshire wide review of targeted community based interventions, including suicide prevention and mental health first aid training			community based interventions will be informed by a review of impact	
- Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and recommend appropriate action(s)	Wellbeing Team, RBC	ongoing	Access to the means of suicide will be reduced where possible	
- Review pages on the Reading Services Guide to include national resources (e.g. 'Help is at Hand' and National Suicide Prevention Alliance resources) and signposting to local services - Map local bereavement support and access to specific support for bereavement through suicide	Wellbeing Team, RBC	June 2017	Those bereaved or affected by suicide will have access to better information and support	
- Ensure local media and communications staff are aware of Samaritans guidance on responsible suicide reporting - Support a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting.	Wellbeing Team, RBC	February 2017 July 2017	Local media will be supported to report on suicide and suicidal behaviour in a sensitive manner	
- Update Reading JSNA module on suicide and self-harm - Refresh Reading Mental Health Needs Analysis .	Wellbeing Team, RBC Adults Commissioning Team, RBC	tbc May 2016	Local and county-wide Suicide Prevention Action will be informed by up to date research, data collection and monitoring	

Appendix 6: West Berkshire Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire. All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners. Launch of strategy at multi-agency suicide prevention summit. Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies. Set up local quarterly meetings to review the action plan	1 April 2017 1 April 2017 15 October 2017 15 October 2017 Quarterly interval
National Strategy			
1. Reduce the risk of suicide in key high-risk groups	Men People who self-harm People who misuse substances People in mental health care	Further development of "Pie and a pint" interventions Promotion of CALM to a wider audience Monitor levels of self-harm Liaising with local substance misuse services Support BHFT in its Zero Suicide Approach	Ongoing work Ongoing work Ongoing work
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training Children and young people	Improve public awareness of suicide Link with West Berkshire Emotional Health Academy Delivery of Adult Mental Health First Aid Training Delivery of Youth Mental Health First Aid Training and MHFA Schools Training	

3. Reduce access to the means of suicide		Support Network Rail, British Transport police and Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 October 2017 Ongoing work
4. Provide better information and support to those bereaved or affected by suicide		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand and National Suicide Prevention Alliance resources) Seek views of those with lived experience on draft action plan Promotion of Newbury SOBs group	Ongoing work Locally determined Ongoing work
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 10 Sept. 2017 1 April 2017
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide. Develop infographics to share with public. Link to W Berks mental health strategy Link to W Berks health and wellbeing strategy	As per JSNA timetable Locally determined

Appendix 7: Wokingham Action Plan 2017-18

Areas for Action	Specific Risk Groups	Action in 2017-18	Timescale by:	Outcome Measure
Overarching Aims		Sign off / endorsement of this Berkshire Suicide Prevention Strategy by all Health & Wellbeing Boards in Berkshire.	1 April 2017	Signed copy of Strategy
		All other local governance completed thus enabling this strategy to be owned by the Local Authorities and their partners.	1 April 2017	Strategy implemented and agreed across the borough
		Launch of strategy at multi-agency suicide prevention summit.	15 Oct. 2017	High profile launch of strategy
		Identify Suicide Prevention Champions to promote the Berkshire Strategy; and to work within the Local Authorities and partner agencies.	15 Oct. 2017	Number of champions identified and trained across the partnership
National Strategy				
1. Reduce the risk of suicide in key high-risk groups	Men	Promotion of CALM to a wider audience	1 June 2017	Widespread awareness of CALM and increase in numbers of men accessing the service
	People in mental health care	Support BHFT in its Zero Suicide Approach	Ongoing work	Evidence of joint working and shared actions
	Occupational Groups	Awareness raising and training for local businesses on identifying early signs and how to respond.		Number of training sessions run
	LGBT groups	Working with local services such as TVPS.		Evidence of joint working and shared actions
	Carers (including young	Work with local carer groups to raise awareness of Mental Health risks and prevention,		Training provided. Information on readily

	carers) and People with LTC People who misuse substances	promote local befriending and support groups. Work with the local treatment provider to ensure that risk of suicide and mental health are part of the assessment.		available from carer groups and networks Suicide risk and mental health area included in standard assessment
2. Tailor approaches to improve mental health in specific groups	Community based approaches Suicide prevention training	Engage with local groups such as faith groups and befriending services. Wellbeing work with tenants services Plan and prioritise a programme of suicide prevention training and integrate into MECC work stream.		Evidence of joint working and shared actions Evidence of joint working and shared actions. Information readily available to staff. Training plan in place.
3. Reduce access to the means of suicide		Support Network Rail, British Transport police and Samaritans with local escalation process locations and general suicide prevention work. Investigate suicides on council owned land and properties, and agree a local action plan. Analyse local data gathered from the suicide audit and/or real-time surveillance to identify trends and clusters and take appropriate action(s) e.g. work with local media.	Ongoing work 15 Oct. 2017 Ongoing work	Robust prevention measures and escalation procedures are in place and all partners are aware of these Case review process established and evidence of reports and actions taken Data shared with partners
4. Provide better information and support to		Promote resources for people bereaved and affected by suicide (e.g. Help is at Hand	Ongoing work	Proportion of people referred to bereavement

those bereaved or affected by suicide		and National Suicide Prevention Alliance resources). Review the availability of support for families and communities bereaved by suicide and affected by near misses. Promote the local Wokingham SOBS group, working with them to identify gaps.	 Locally determined Ongoing work	services Needs assessment carried out Evidence of promotional work and partnership working
5. Support the media in delivering sensitive approaches to suicide and suicidal behaviour		Convene a Berkshire-wide Summit on journalism and reporting standards with local press and media organisations, to develop and agree standards for reporting. Agree a local action plan with the local communications team to support this aim. Identify a lead officer to monitor internet and both local and social media. Challenge stigma: Media campaign to support world suicide prevention day Update council and stakeholder webpages to ensure effective signposting for those bereaved by suicide	20 July 2017 20 July 2017 Ongoing work 1 Sept. 2017 1 April 2017	Summit organised and reporting standards published. Reduced stigma around suicide and reduction in copycat suicides. Suicides are reported appropriately and sensitively. Communication Action Plan Officer identified Campaign held Webpages up to date and those bereaved access support
6. Support research, data collection and monitoring		To update data on the JSNA summary on suicide.	As per JSNA timetable	JSNA suicide chapter up to date

Appendix 8: Membership of the Berkshire Suicide Prevention Steering Group as at December 2016

Angela Baker	Deputy Centre Director	PHE South East
Angus Tallini	GP and Mental Health lead for Berkshire West CCGs	Newbury & District NHS CCG
Anthony Barrett		NHS
Belinda Dixon		RBWM
Caroline Attard	Nurse Consultant, In-patient wards	Berkshire Healthcare Foundation NHS Trust
Carol-Anne Bidwell	Public Health Programme Officer	Wokingham Borough Council
Charlotte Ryall	Coroner's Officer	Reading Borough Council
Chris Allen		NHS
Colin Bibby		SEAP
Daren Bailey		Berkshire Healthcare Foundation NHS Trust
Darrell Gale	Consultant in Public Health	Wokingham Borough Council
Debbie Daly	Director of Nursing and Quality	NHS Berkshire West CCGs
Eugene Jones		Berkshire Healthcare Foundation NHS Trust
Geoff Dennis		Berkshire Healthcare Foundation NHS Trust
Gillian McGregor		Reading Council
Gwen Bonner	Clinical Director Reading Locality Clinical Director Research	Berkshire Healthcare Foundation NHS Trust
Helen Ranasinghe		Samaritans
Helena Fahie	Public Health Support Manager	PHE South East
Janette Searle	Preventative Services Development Manager	Reading Borough Council
Jason Jongali	Head of Mental Health & Learning Disability Commissioning	NHS Berkshire West CCGs
Jillian Hunt		Bracknell Forest Council
Jo Greengrass		NHS
Jonathan Groenen		Thames Valley Police
Julia Wales,		Slough Council
Kate Jahangard		Reading Council
Katie Simpson	GP and Mental Health lead for Berkshire East CCGs	NHS CCG
Ken Hikwa		Berkshire Healthcare Foundation NHS Trust
Kim McCall		Reading Borough Council
Lesley Wyman	Consultant in Public Health	West Berkshire Council
Lisa McNally	Consultant in Public Health	Bracknell Forest Council
Lise Llewellyn	Strategic Director of Public Health	Public Health Services Berkshire
Natalie Mears	Public Health Programme Officer	RBWM
Mark Spencer	Detective Chief Inspector; Deputy Commander - Slough	Thames Valley Police
Sally Murray	Head of Children's Commissioning	NHS Berkshire West CCGs
Nadia Barakat	Head of Mental Health & Learning Disabilities Commissioning	NHS Berkshire East CCGs
Nick Davies		RBWM

Rachel Johnson	Public Health Programme Officer	West Berkshire Council
Ramesh Kukar		Slough Council of Voluntary Services
Reva Stewart	Locality Director	Berkshire Healthcare Foundation NHS Trust
Richard Tredgett		Reading Samaritans
Rukayat Akanji-Suleman	Public Health Programme Officer	Slough Borough Council
Safron Simmonds	Project Manager	NHS Berkshire West CCGs
Sarah Bellars		NHS
Sue McLaughlin	Clinical Director / Nurse Consultant Slough locality	Berkshire Healthcare Foundation NHS Trust
Susanna Yeoman		Berkshire Healthcare Foundation NHS Trust
Tandra Forster	Head of Adult Social Care	West Berkshire Council
Tanya Demonne	Mental Health Coordinator, Safeguarding	Royal Berkshire Hospital Foundation NHS Trust
Timothy Foley		SEAP
Tony Dwyer		Berkshire Healthcare Foundation NHS Trust

Back Cover to be designed and add contact details of Shared Team etc.

URL of Strategy

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Integration and Mental Health: Briefing for Berkshire West 10 Delivery Group 25.01.2017

Introduction
This paper aims to support a discussion regarding the current position, what is going well, where we are experiencing difficulties, and what are our recommended next steps to communicate to the Integration Board.

Background
The Five Year Forward View for Mental Health (FYFV for MH) provides an important source of national guidance for evidence-based development of mental health services. It was informed by a significant national engagement exercise, which included over 20,000 responses, as well as an economic analysis by the Centre for Mental Health. This is an important document which provides guidance about the return on investment which can be achieved for a range of mental health initiatives.

Berkshire Healthcare has developed a local mental health strategy working with commissioners and partners for 2016 - 21. This was informed by:

- A literature review including national guidance – in particular the FYFV for MH, NICE and good practice evidence
- A review of what service users and carers have said about what is important to them (including the national engagement exercise to inform the development of the Five Year Forward View for Mental Health)
- Key public health messages about mental health problems and our local population
- The expertise and knowledge of clinicians and leaders.
- The vision and values of the organisation as a whole

The summary document outlining the Berkshire Healthcare MH Strategy (attached) was approved by the Trust Board and implementation plans for Child and Adolescent, Adults of Working Age and Older Adults are in development.

It is recognised that each Local Authority is at a different stage in terms of its own strategic priorities, and approach to development of local strategy, and the aim is to work in a way that makes sense in terms of local need, but maintains a coherent, Berkshire-wide approach.

What is going well?

- Strong foundation of good quality services, financial performance and governance (Berkshire Healthcare rated “good” by the Care Quality Commission and within segment 1 of the NHS Improvement Single Oversight Framework).
- Most priorities within the FYFV for MH have been supported by commissioner investment, which will facilitate achievement of performance targets.
- National investment has been secured for IAPT (to increase access for MH and develop services for long term physical health problems) and Perinatal Services.
- Bids have been submitted for Transformation Funding for MH Liaison Services via the STP (in line with NHSE Guidance).
- Innovative use of technology to provide online access to treatment and support.
- Single point of access to mental health services now being developed to include social care.
- Specific services have a national reputation for quality and innovation (including Early Intervention in Psychosis, IAPT, Community Teams for Older People etc)

What are our difficulties?

- Demand pressures, within finite funding available has caused an increase in out of area placements for people who need acute inpatient treatment, as well as those who need specialist treatment. This is not acceptable for patients and their families and also causes significant cost pressures.
- Local Authorities have been required to make significant savings, which inevitably impact on MH Services and people who use them.
- Meeting the needs of people presenting at RBH A&E with psychological problems is presenting a significant challenge: further analysis is needed to ensure that we understand the different cohorts of people needing help and address their needs appropriately.
- Delayed transfers of care from MH Inpatient services has a number of causes, including section 117 issues and difficulties securing accommodation.
- Street Triage and Individual Placement (supporting people into employment)Services are not funded recurrently despite the evidence-based contribution they make in supporting people to move on from specialist mental health services
- Bed Occupancy levels at or over 100% have been reached regularly (85% is the recommended level)
- Workforce shortages – these are particularly challenging in Inpatient Services, but a Prospect Park Development Programme has been established and initial results being achieved are encouraging.
- Dual Diagnosis – the commissioner and provide landscape in Berkshire is complex, with different arrangements in each area for addressing the needs of people with combined substance misuse/alcohol problems and mental illness. Inpatient Services have experienced an increase in the number of people being admitted with dual diagnosis, and community based services for people with the most complex services are limited.
- Despite significant progress in reducing waiting times for CAMH Services, waits for people needing to access the Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder Pathways are slower to improve.

Potential Recommended Next Steps for approval by Delivery Group

1. H&WB Board discussions on Mental Health in each area to clarify local priorities, and approach to strategy implementation.
2. Berkshire West Strategy Steering Group established with representatives linked to local governance arrangements appropriate to each area.
3. Inclusion of Berkshire West key projects in Delivery Group monitoring, along with progress in reducing delayed transfers of care from MH Inpatient Services. NB this is not intended to duplicate existing reporting e.g. through A&E Delivery Board.

Bev Searle, Director of Corporate Affairs, Berkshire Healthcare in liaison with Gabrielle Alford, Director of Joint Commissioning, Berkshire West CCGs

Better Care Fund 2017/19 - Summary Report

Committee considering report:	Health and Wellbeing Board
Date of Committee:	01 March 2017
Portfolio Member:	Councillor Graham Jones
Date Portfolio Member agreed report:	03 March 2017
Report Author:	Tandra Forster
Forward Plan Ref:	EX3218

1. Purpose of the Report

1.1 To inform the Health and Wellbeing Board about draft plans for the Better Care Fund.

2. Implications

2.1 Funding allocations are still to be determined but are likely to be minimal; estimates are 1.79% in 2017/18 and 1.9% 2018/19. Whilst plans will be agreed for two years there will still be some flexibility to make adjustments should the need arise. The additional funding announced in the Spring Budget 2017 will be ring fenced for Adult Social Care, we are awaiting detailed guidance but understand there will be conditions in relation to how it can be used.

3. Other options considered

3.1 N/A

4. Executive Summary

4.1 The Better Care Fund (BCF) is a government initiative established to fast track integration with Health and Social Care. 2015/16 was the first year of implementation, all Councils and CCGs had to agree a plan and then obtain approval from their Health and Wellbeing Boards

4.2 There has been a delay in issuing the national guidance; we understand this is likely now to be towards the end of week commencing 20th March 2017. Advice from the Better Care Team is that all localities will have 7 weeks to write, agree and submit plans to NHS England by 12th May 2017.

4.3 Going forward it is still the intention that where systems are able to demonstrate real progress in their plans for integration it will be possible to 'graduate' from the BCF process. Neither the process nor criteria for this has been agreed but it is believed that from 6 – 10 systems will graduate in 2017/18.

5. Conclusion

5.1 The 2015/16 BCF has provided significant learning that should allow us to build on plans for the coming year. Delays in publishing the national guidance have created a degree of uncertainty but we have continued to develop local plans. This is reflective of the approach in both Reading and Wokingham Localities.

6. Appendices

6.1 Appendix A - Supporting Information

6.2 Appendix B – Equalities Impact Assessment

Appendix A

Better Care Fund 2017/19

1. Introduction/Background

1.1 The Better Care Fund (BCF) is a government initiative established to fast track integration with Health and Social Care. 2015/16 was the first year of implementation, all Councils and CCGs had to agree a plan and then obtain approval from their Health and Wellbeing Boards.

1.2 The previous two years have required us to plan on an annual basis. The Better Care Team has now confirmed that the plans will be for two years. This will align them more closely with CCG financial planning.

1.3 Funding allocations are still to be determined but are likely to be minimal; estimates are 1.79% in 2017/18 and 1.9% 2018/19. Whilst plans will be agreed for two years there will still be some flexibility to make adjustments should the need arise.

1.4 Going forward it is still the intention that where systems are able to demonstrate real progress in their plans for integration it will be possible to 'graduate' from the BCF process. Neither the process nor criteria for this has been agreed but it is believed that from 6 – 10 systems will graduate in 2017/18.

2. BCF National Policy Framework - Assurance

2.1 There has been a delay in issuing the national guidance; we understand this is likely now to be towards the end of w/c 20th March 2017. Advice from the Better Care Team is that all localities will have 7 weeks to write and agree their plans, with the submission date being the 12th May 2017. They have also advised that the National Conditions will reduce from 8 to 4, see below:

- Plans to be jointly agreed
- Maintaining the provision of social care services
- Agreement to invest in NHS out of hospital services, which may include a wide range of services including Social Care
- Agreement on local action plan to reduce delayed transfers of

2.2 The Spring Budget on 8th March 2017 announced additional funding for Local Authorities over the next 3 years. This funding will be ring fenced for Adult Social Care. We have been advised conditions will apply to this funding, we await formal guidance. West Berkshire will receive £704,449 in 2017/18, £583,666 in 2018/19 and £281,912 in 2019/20.

3. West Berkshire Locality BCF Plan

3.1 A number of planning meetings have been held with the CCG; please see attached the latest draft plan, which is still work in progress and will be finalised following publication of the national guidance. For the overarching financial plan we have worked on the basis of a 1.79% increase on the revenue elements of the Better Care Fund.

3.2 In addition to the revenue amounts we anticipate that the Disabled Facilities Grant will continue to be paid through the BCF.

3.3 In the new plan the Joint Care Pathway will be confirmed as 'business as usual'. Given the change in status it has already been agreed that this funding will be added to the 'Maintain the provision of social care services'.

3.4 This year we have reduced the investment into 7 days services to £155k. This will require an adjustment to the current arrangement. The remaining funding will be used to fund a new 'step down' project in Birchwood Care Home; the project team have modelled the proposed arrangement on the Willows a successful service operated by Reading Council.

3.5 The BCF also includes funding for West of Berkshire projects. These include 'Connected Care' ,an ICT project that aims to support more effective information sharing across health and social care, a key requirement of any integration programme and 'Care Homes' which focuses on reducing the disproportionately high number of non elective admissions from care homes.

3.6 The West of Berkshire projects have been expanded to incorporate the Mental Health Street Triage. This reflects the intention of expanding the BCF to incorporate a broader range of priorities.

3.7 Subject to any change resulting from the publication of the BCF guidance we have limited funding. This means that we are not currently able to agree to other projects which would enhance the range of support to the local residents.

3.8 We have also agreed with the CCG to include investment related to the contract held with BFHT. This covers a range of services including intermediate care, speech and language therapy and the community geriatrician.

4. BCF Assurance Process

4.1 For 2017/18 the BCT have confirmed the assurance process will continue to be managed collaboratively between NHS England, the Local Government Association and Association of Directors of Adult Social Care. Initially there were three milestone dates, given the delay it is likely to be reduced to one.

5. Conclusion

5.1 The 2015/16 BCF has provided significant learning that should allow us to build on plans for the coming year. Delays in publishing the national guidance have created a degree of uncertainty but we have continued to develop local plans. This is reflective of the approach in both Reading and Wokingham Localities.

5.2 It is recommended, that the Board agrees the latest draft plan and gives the Locality Integration Board delegated authority to approve the plan in order that the submission date of 12th May 2017 is achieved.

6. Consultation and Engagement

West Berkshire Locality Integration Board

Background Papers:

Subject to Call-In:
Yes: ☐ No: ☒

The item is due to be referred to Council for final approval	☐
Delays in implementation could have serious financial implications for the Council	☒
Delays in implementation could compromise the Council's position	☐
Considered or reviewed by Overview and Scrutiny Management Commission or associated Task Groups within preceding six months	☐
Item is Urgent Key Decision	☐
Report is to note only	☐

Strategic Aims and Priorities Supported:
The proposals will help achieve the following Council Strategy aim:
☒ **P&S – Protect and support those who need it**

Officer details:

Name: Tandra Forster
Job Title: Head of Adult Social Care
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Appendix B

Equality Impact Assessment - Stage One

We need to ensure that our strategies, polices, functions and services, current and proposed have given due regard to equality and diversity.

Please complete the following questions to determine whether a Stage Two, Equality Impact Assessment is required.

Name of policy, strategy or function:	Better Care Fund Programme 2016/17
Version and release date of item (if applicable):	V.01
Owner of item being assessed:	Tandra Forster
Name of assessor:	Tandra Forster
Date of assessment:	10th March 2016

Is this a:		**Is this:**	
Policy	**No**	**New or proposed**	**No**
Strategy	**Yes**	**Already exists and is being reviewed**	**Yes**
Function	**No**	**Is changing**	**No**
Service	**No**		

1. What are the main aims, objectives and intended outcomes of the policy, strategy function or service and who is likely to benefit from it?	
Aims:	The Better Care Fund Programme is a initiative established to promote greater integration between health and social care.
Objectives:	To outline the project initiatives and associated investment for the West Berkshire Locality Better Care Fund.
Outcomes:	The range of projects will help promote better integration between health and social care services, meet the national conditions as set out in the Better Care Fund Policy Framework.
Benefits:	Improved the experience of health and social care services for local residents by reducing duplication of services, increase access to health and social care by implementing 7 day work, better information sharing, protecting existing provision of social care.

2. Note which groups may be affected by the policy, strategy, function or service. Consider how they may be affected, whether it is positively or negatively and what sources of information have been used to determine this.

(Please demonstrate consideration of all strands – Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion or Belief, Sex and Sexual Orientation.)

Group Affected	What might be the effect?	Information to support this
Age	Improved access to services both in terms of pathways and availability	National conditions - see attached BCF Policy Framework Range of projects within the locality support this and robust assurance process is in place to ensure compliance.
Disability (frail elderly)	Improved access to services both in terms of pathways and availability	National conditions - see attached BCF Policy Framework Range of projects within the locality support this and robust assurance process is in place to ensure compliance.
Gender	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Marriage and civil partnership	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Pregnancy and maternity	No impact	This programme of work is currently focused on frail elderly
Race	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Sex	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Sexual Orientation	This is not a distinguishing factor in this service	This is not a distinguishing factor in this service
Further Comments relating to the item:		

3. Result	
Are there any aspects of the policy, strategy, function or service, including how it is delivered or accessed, that could contribute to	**No**

inequality?	
Please provide an explanation for your answer: The proposals are intended to enhance service provision and outcomes for service users/patients	
Will the policy, strategy, function or service have an adverse impact upon the lives of people, including employees and service users?	**No**
Please provide an explanation for your answer: The proposals are intended to enhance service provision and outcomes for service users/patients. Appropriate arrangements are in place which mean employees are not disadvantaged by any new arrangements.	

If your answers to question 2 have identified potential adverse impacts and you have answered 'yes' to either of the sections at question 3, or you are unsure about the impact, then you should carry out a Stage 2 Equality Impact Assessment.

If a Stage Two Equality Impact Assessment is required, before proceeding you should discuss the scope of the Assessment with service managers in your area. You will also need to refer to the Equality Impact Assessment guidance and Stage Two template.

4. Identify next steps as appropriate:	
Stage Two required	
Owner of Stage Two assessment:	
Timescale for Stage Two assessment:	
Stage Two not required:	X

Name: Tandra Forster **Date: 10.03.16**

Please now forward this completed form to Rachel Craggs, the Principal Policy Officer (Equality and Diversity) for publication on the WBC website.

Title of Report:	**Feedback from the Hot Focus Session: Systems Resilience Dashboard**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	30 March 2017

Purpose of Report:

To inform the Health and Wellbeing Board (the Board) of the outcome of the Hot Focus Session held on 23 February 2017 to refresh the Systems Resilience Dashboard.

Recommended Action:

That the Board approve the new approach of performance monitoring and problem solving:

Future Health and Wellbeing Development Sessions (private meetings in between Board meetings) will feature a standing item for members to share 'good news' stories and organisational resilience concerns.

A new performance reporting framework will be developed to report indicators linked to the Health and Wellbeing Strategy. The Steering Group will receive the information and ensure that exception reports are provided to the Board on issues with exceptional over or under performance.

The Board will consider the performance of the West Berkshire system in comparison with other areas annually as part of its Annual Report.

Future Hot Focus Sessions will be renamed 'Problem Solving Sessions' and will use the Community Conversations approach to identify and resolve system resilience issues.

Reason for decision to be taken:	So that the Board can have the tools it needs in order to fulfil its role as system leaders.
Other options considered:	To make no changes to the dashboard – rejected as the current dashboard does not take into account the whole West Berkshire 'system' which is now reflected in the membership of the Board.
Key background documentation:	n/a

Health and Wellbeing Board Chairman details	
Name & Telephone No.:	Graham Jones – Tel 07767 690228
E-mail Address:	graham.jones@westberks.gov.uk

Contact Officer Details	
Name:	Jo Reeves
Job Title:	Principal Policy Officer (Executive Support)
Tel. No.:	01635 519486
E-mail Address:	Joanna.Reeves@westberks.gov.uk

Implications

Policy:	There are no policy implications arising from this report.
Financial:	There are no financial implications arising from this report. .
Personnel:	There are no personnel implications arising from this report.
Legal/Procurement:	There are no legal or procurement implications arising from this report.
Property:	There are no property implications arising from this report
Risk Management:	The Board will be taking a new approach to risk management whereby exception reporting on emerging issues will be lead by the Steering Group.

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	☐
• Is it a major policy, significantly affecting how functions are delivered?	☐	☐
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	☐
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	☐
• Does the policy relate to an area with known inequalities?	☐	☐
Outcome (Where one or more 'Yes' boxes are ticked, the item is relevant to equality)		
Relevant to equality - Complete an EIA available at www.westberks.gov.uk/eia		☐
Not relevant to equality		☒

Executive Report

1. Introduction

1.1 The Health and Wellbeing Board developed the Systems Resilience: Health and Social Care Dashboard in 2014. The dashboard was split into three areas including Adult Social Care, Children's Social Care, Primary Care and the Acute sector.

1.2 The dashboard was not intended to monitor performance against the Health and Wellbeing Strategy and instead had the aim that the information would flag up immediate issues across the system that could help to indicate system resilience and lead to problem solving.

1.3 In March 2015, the Local Government Association (LGA) was invited to conduct a Peer Challenge of the Health and Wellbeing Board. In light of the recommendations which arose, the Board has refreshed the joint Health and Wellbeing Strategy and has implemented a new governance structure which uses sub-groups to drive work against areas of the Strategy. The recommendations also indicated that the Board needed to strengthen performance management and continue to hold difficult discussions about critical and important issues.

1.4 So that the Board can continue to make changes to address the areas that the Peer Challenge identified as areas of improvement, the Hot Focus Session on 23 February was used to refresh the Dashboard.

2. Hot Focus Session on 23 February 2017

2.1 The session was held between 9am and 12pm at Shaw House in Newbury and was facilitated by Catalin Bogos – Research, Consultation and Performance Manager and Jo Reeves, Principal Policy Officer for West Berkshire Council. It was well attended by Board members and officers.

2.2 Councillor Graham Jones and Dr Bal Bahia (Chairman and Vice-Chairman of the Health and Wellbeing Board) opened the session by giving a presentation which summarised the changes the Board had made over the past year and set the context for revising the Dashboard.

2.3 They outlined that the dashboard needed to:

(1) take into account the system represented at the Board.

(2) include the most relevant measures.

(3) be up-to-date.

(4) facilitate problem solving.

2.4 Attendees were invited to identify the strengths of the current dashboard and areas for improvement.

2.5 Strengths:

(1) The measures reporting on the Acute Sector were appropriate

(2) It provided an overview

(3) The narrative sections were helpful

2.6 Areas for Improvement:

(1) There were still no measures reporting on the resilience of Primary Care

(2) There were no demand measures

(3) It did not lead to difficult conversations to drive action and problem solving

(4) The Children's Delivery Group could escalate key indicators for the children's section which was now performing well

(5) Resilience was not defined

2.7 Catalin Bogos then gave a presentation which explained the different types of measures the Board could use in its Dashboard. He used the analogy of a car's dashboard which could show up to 63 indicators of the car's performance but only showed the ones that the driver would need to use during their journey and any warnings if there was a problem.

2.8 The attendees were invited to comment on what the dashboard should be used for and concluded that its purpose should be to:

(1) report the performance of the sub-groups

(2) give organisations an opportunity to discuss their issues and call for help if needed

(3) give a 'heads up' on areas of concern

(4) share good news

(5) monitor demand and capacity

(6) facilitate annual comparison

2.9 The attendees concluded that the approach they wanted to take could not necessarily be made possible by only making changes to the dashboard. Instead, there could be a new way of working together which could be used to facilitate problem solving and holding difficult discussions.

2.10 They identified that the Board had chosen 'community conversations' as one of their areas of focus for 2017 and considered that the community conversation approach to problem solving could be used within their own 'community' of system leaders.

3. Next Steps

3.1 Going forward, the attendees agreed that the Board would take the following approach to monitoring performance, monitoring system resilience and problem solving:

- **Conversations:** Future Health and Wellbeing Development Sessions (private meetings in between Board meetings) will feature a standing item for members to share 'good news' stories and organisational resilience concerns. Board members will be trusted to attend with the information they need in order to have meaningful conversations.

  Timescale: the Health and Wellbeing Development Session to be held on 6 July 2017 will include this discussion. The Steering Group are asked to steer on whether in addition, time should be found before the Board meetings in March and May.

- **Performance Monitoring:** A new performance reporting framework will be developed to report indicators linked to the Health and Wellbeing Strategy. The Steering Group will receive the information and ensure that exception reports are provided to the Board on issues with exceptional over or under performance.

  Timescale: a new draft will be developed based on the sub-groups' Strategic Action Plans for the Steering Group and Board meetings in May.

- **Benchmarking:** The Board will consider the performance of the West Berkshire system in comparison with other areas annually as part of its Annual Report. This information will be used to inform the Board's future annual areas of focus.

  Timescale: the Annual Report is currently on the Forward Plan for January 2018

→ **Problem Solving:** The above mechanisms need to lead to action. Future Hot Focus Sessions will be renamed 'Problem Solving Sessions' and will use the Community Conversations approach to identify and resolve system resilience issues. These sessions would include a more varied attendance list in order to facilitate creativity and a broad discussion.

  Timescale: The next Hot Focus session is scheduled for 29 June 2017 and a problem solving session will be held on a subject to be confirmed.

3.2 Other actions were identified which would enable the above framework being implemented:

(1) A mechanism to make decisions outside of Board meetings would be investigated and implemented if possible. *(Jo Reeves to take forward.)*

(2) Report templates could clarify what action is required of the Board and how it links to the Health and Wellbeing Strategy. *(Jo Reeves to take forward.)*

(3) Topics for the "conversations" could be based on known system resilience issues and be pre-determined by the Steering Group. *(Steering Group to take forward.)*

4. Conclusion

4.1 The outcomes of the Hot Focus Session demonstrate that the Board members consider themselves to be a community that is willing to adapt to new ways of working to continue to build on their strong relationships and to ensure that the way they work together is effective.

4.2 The Steering Group will be instrumental in ensuring effective forward planning of the Board's public meetings, development sessions and Hot Focus, now 'Problem Solving' sessions to enable the Board to monitor the system's performance and its resilience.

Consultees

Local Stakeholders:	Health and Wellbeing Board members, the Health and Wellbeing Steering Group members, Health and Wellbeing Sub-Group Chairs and Lead Officers.
Officers Consulted:	Research, Consultation and Performance team at West Berkshire Council, performance teams of the CCG, RBFRS and TVP.
Trade Union:	n/a

Title of Report:	**Report to the Health and Wellbeing Board from the Steering Group**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	30 March 2017

Purpose of Report:

To inform members of the Health and Wellbeing Board of the latest progress achieved by its sub-groups in delivering the Health and Wellbeing Strategy.

To highlight any emerging issues which requires the Board members' attention.

Recommended Action:

The Board note the report and provide direction where needed.

Reason for decision to be taken: To ensure that the Health and Wellbeing Strategy is delivered.

Other options considered: n/a

Key background documentation: Joint Health and Wellbeing Strategy 2017-2020
Governance Arrangements for the Health and Wellbeing Board

Contact Officer Details	
Name:	Jo Reeves
Job Title:	Principal Policy Officer (Executive Support)
Tel No:	01635 519486
E-mail Address:	Joanna.Reeves@westberks.gov.uk

Implications

Policy:	None
Financial:	None .
Personnel:	None
Legal/Procurement:	None
Property:	None
Risk Management:	None

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	☐
• Is it a major policy, significantly affecting how functions are delivered?	☐	☐
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	☐
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	☐
• Does the policy relate to an area with known inequalities?	☐	☐
Outcome (Where one or more 'Yes' boxes are ticked, the item is relevant to equality)		
Relevant to equality - Complete an EIA available at www.westberks.gov.uk/eia		☐
Not relevant to equality		☒

Executive Report

1. Introduction

1.1 Since the Peer Challenge in March 2016, the Health and Wellbeing Board has made a number of changes to the way that it operates.

1.2 A refreshed Strategy was agreed by the Board on 26 November 2016 and approved by the Council on 2nd March 2017. This reduced the number of priorities to two priorities for 2017 and five strategic aims.

Table 1 - The aims (3 year) and short term priorities (1 year) for the Health and Wellbeing Board

Aims (3 year)

1. Give every child the best start in life
2. Support mental health and wellbeing throughout life
3. Reduce premature mortality by helping people live healthier lives
4. Build a thriving and sustainable environment in which communities can flourish
5. Help older people maintain a healthy, independent life for as long as possible

Short Term Priorities (1 year)

- Reducing alcohol related harm
- Enhancing 'community conversations'

1.3 The Board has also approved a new governance structure which includes a Steering Group and several sub-groups.

1.4 One of the Steering Group's objectives is to ensure that effective programme and performance management arrangements are put in place with regard to delivery of the Board's objectives and priorities.

1.5 In order to ensure that the Board's strategy is being delivered, the Steering Group holds the Chairs of the sub-groups to account.

2. Performance Management

2.1 In order to clarify how the Health and Wellbeing Strategy will be delivered, the Chairs of the sub-groups have been asked to develop strategic action plans. These plans clarify the sub-group's objectives, intended impacts, key performance indicators and actions.

2.2 Strategic action plans are ready for the Alcohol Harm Reduction Partnership and Building Community Together Partnership, the two groups which will be delivering against the Health and Wellbeing Board's two areas of focus for 2017 (reducing alcohol related harm and enhancing community conversations.)

2.3 The Alcohol Harm Reduction Partnership has used the CLEAR tool to 'stock take' services in West Berkshire. A more detailed report is provided as agenda item 10b.

2.4 Building Communities Together Partnership: This partnership will come into being on 13th May 2017 and will be supported by the new Building Community Together Team from 1st April 2017, which includes officers form the Council and Thames Valley Police. The tem manager has completed a review of community conversations, provided as agenda item 10a.

2.5 The next steps will be for the remaining sub-groups to refine their action plans to identify what projects or targeted interventions can be implemented beyond work that is already contained in member organisations operating plans.

2.6 The key performance indicators that the sub-groups identify will form the new performance dashboard. The timescale for the Health and Wellbeing Board to see a draft of the new dashboard will be at the meeting to be held on 25th May 2017.

2.7 The Steering Group have also considered how progress continues to be reported to the Health and Wellbeing Board and have concluded that the sub-groups Chairs will be required to complete highlight reports to summarise the progress of their projects.

3. Matters for the Health and Wellbeing Board's attention

3.1 At their meeting on 2 March 2017, the Steering Group received a report regarding Special Education Needs and Disability (SEND) Reforms and the progress made since the implementation of the legislation in 2014.

3.2 The report summarised the findings of an evaluation completed by the SEND Reform Steering Group and identified a number of strengths and areas for improvement relating to the six themes investigated:

(1) Engagement of children and young people with SEND and their parents / carers and access to information and advice

(2) Effectiveness of the local area in identification of children and young people's SEN and / or disabilities

(3) Effectiveness of the local area in assessing and meeting the needs of children and young people with SEN and / or disabilities

(4) Effectiveness of transitions between phases and between services

(5) Effectiveness of the local area in improving outcomes for children and young people who have SEN and / or disabilities

(6) Effectiveness of joint commissioning arrangements

3.3 A number of these areas for development were already being addressed and it is recommended that the Health and Wellbeing Board consider the full report and contribute to an Action Plan to address the areas for development, to be overseen by the SEND Reform Steering Group.

3.4 The Steering Group considered that there was not yet a draft action plan and it might be more helpful to present a draft action plan to the Health and Wellbeing Board once it is developed.

3.5 Steering Group members considered what role the Health and Wellbeing Board could play in the SEND Reform action plan and noted that transitions from children's to adult's services was a particular issue. They determined that SEND transitions would benefit from a problem solving session, attended by HWB Board members and other stakeholders, to find solutions to improve children's experience when moving from one phase or service to another.

4. Conclusion

4.1 The Steering Group has been overseeing the production of strategic action plans by the Chairs of the Health and Wellbeing Board's sub-groups.

4.2 Plans are available for the Alcohol Harm Reduction Partnership and the Building Community Together Partnership. Plans for the other sub-groups will be presented to the Health and Wellbeing Board when they are available.

4.3 The Steering Group recommend that SEND transitions becomes the subject of one of the Health and Wellbeing Board's problem-solving sessions.

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Title of Report:	**Review of Community Conversations**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	30 March 2017

Purpose of Report:

To provide the Health and Wellbeing Board with information on progress to date with Community Conversations

Recommended Action:

That the Health and Wellbeing Board note the information and discuss the areas for future development outlined in section 14.

Key background documentation: None

Contact Officer Details	
Name:	Susan Powell
Job Title:	Safer Communities Partnership Team Manager
Tel. No.:	07881856801
E-mail Address:	Susan.Powell@westberks.gov.uk

Implications

Policy:	Continuation and development of the Building Communities Together initiative
Financial:	A Building Communities Together Grant of £19,249 was awarded to Empowering West Berkshire in March 2016 to co-facilitate Community Conversations. This responsibility transferred to the Volunteer Centre West Berkshire in October 2016. Funding is being utilised to support Community Conversations covering the cost of renting space, refreshments, mileage and officer time.
Personnel:	The newly formed Building Communities Together Team (April 2017) to assume responsibility for Community Conversations
Legal/Procurement:	None
Property:	None
Risk Management:	

Is this item relevant to equality?	Please tick relevant boxes	**Yes**	**No**

Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	X
• Is it a major policy, significantly affecting how functions are delivered?	☐	X
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	X
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	X
• Does the policy relate to an area with known inequalities?	☐	X
Outcome (Where one or more 'Yes' boxes are ticked, the item is relevant to equality)		
Relevant to equality - Complete an EIA available at www.westberks.gov.uk/eia	☐	
Not relevant to equality	X	

Executive Report

1. Introduction

1.1 The Health and Wellbeing Board has adopted the following as a Strategic Priority for 2017/18:

Increase the percentage of communities where community conversations have successfully run and local action plans have been jointly developed

1.2 The Board has requested an update on progress of Community Conversations from the Building Communities Together Partnership which is being formed as a sub group within the new governance arrangements.

1.3 Community Conversations commenced in March 2016 under the Building Communities Together Programme and to date progress has been reported to the Brilliant West Berkshire Programme Board.

1.4 The Building Communities Together programme has sought to empower local communities and individuals to find their own sustainable solutions to improve quality of life and reduce the likelihood of residents needing more specialist help.

1.5 The Strategic Priorities of the Building Communities Together programme are:

- Improving mental health
- Reducing school exclusions/increasing attainment
- Increasing return to employment and training
- Increasing domestic abuse reporting – reducing repeat abuse
- Increasing take-up of alcohol/substance misuse support

1.6 The aim of Community Conversations within the Building Communities Together programme was to:

Develop a community led restorative approach

1.7 Responsibility for the coordination and further development of Community Conversations will be the responsibility of the new Building Communities Together Team from April 2017 and it is timely therefore to review progress to date and consider future direction and potential development.

2. Selection of Communities and instigation of Conversations

2.1 Communities were selected for this initiative based on data analysis conducted in July 2015. The data fields included:

- Police reports
- Anti-social behaviour
- Youth re-offending
- Looked after Children
- Adults in contact with Community Mental Health Services
- Children receiving early intervention
- Children on Child Protection Plans
- Economically active residents
- Young people on waiting list for Child and Adolescent Mental Health Services

2.2 In addition to the analysis of data some communities were also selected for inclusion based on existing work within them that offered potential for community engagement.

2.3 The Communities identified for this initiative were:

- Hungerford and Lambourn Valley
- Calcot
- Thatcham
- Burghfield and Mortimer
- Greenham

2.4 Empowering West Berkshire was awarded a Building Community Together Grant in March 2016 to co-facilitate Community Conversations in each of the locations identified and this responsibility subsequently transferred to the Volunteer Centre West Berkshire in October 2016.

2.5 Community Conversations have been instigated in 4 of the 5 communities selected and arising from some there has been notable change and achievements.

3. Community Anchors

3.1 It was identified that in order to establish Community Conversations in addition to co-facilitation there would need to be a resource within the community to support their development. The concept of Community Anchors was established and a number were engaged and 'trained' at the start of the initiative. Currently there are only a few still 'active' and there have been a number of very valid reasons why Community Anchors have had to 'stand down' from their role including sickness, redundancy and changing roles.

3.2 New Community Anchors are being trained in Restorative Practice in February 2017 with the intention of running a targeted conversation in Newbury facilitated by Newbury Baptist Church and supported by partner agencies.

4. Community Conversations and Achievements

4.1 The following is a brief summary on each Conversation.

<u>Hungerford and Lambourn</u>

Conversations held on following dates:

- 2/216
- 9/2/16
- 25/4/16
- 29/6/16
- 4/10/16

These conversations have benefitted from an extremely effective Community Anchor and there has been active participation of a good number of local residents and multi agency staff.

Topics of conversations have included:

- School transport
- Building a sense of community cohesion
- Helping parents with more challenging home situations manage and look after their children
- Designing innovative approaches to pastoral support and inclusion within primary and secondary schools
- Supporting professionals on how best to work together to meet emerging needs early
- Local charity working with more vulnerable young people to give them a positive experience of producing a film
- Social isolation
- Community transport

A group of 7 volunteers started a youth club for children with additional needs who attend a mainstream secondary school. This is now running successfully and is affiliated to Berkshire Youth.

Depression Alliance is exploring the potential to expand their services into Hungerford to work with people who have mental health problems using peer to peer support groups.

A group of faith based volunteers came together to provide a Christmas dinner for around 50 people who would otherwise have been on their own thus reducing social isolation.

In response to a request for the opportunity to meet and discuss shared issues and challenges and to be able to share support, signposting and solutions a multi agency professionals forum has been established. The discussions are thematic including anti-social behaviour and domestic abuse.

More detailed information on the Hungerford Community Conversation is given in Appendix 1.

Calcot

Conversations held on following dates:

- 26/1/16
- 18/6/16
- 10/10/16

Topics of conversations have included:

- Transport
- Communication on community events and resources

Due to changes in Community Anchors it has been challenging to get Community Conversations well established however some ‘scoping’ of local initiatives has taken place.

Friday Friends is an informal group of generally older members of the community who come together to share a cup of tea and play games.

Lack of transport to enable older people to get to supermarkets or to attend local groups has been identified as an issue.

The need to improve communication has also been identified as an issue. There are some community orientated communication mechanisms but they are not well coordinated.

In order to re-energise activities Love Your Community (formerly St Birinus Church) are due to launch a public facing Community Conversation in March 2017.

Thatcham

Conversations held on following dates:

- 2/2/16
- 17/2/16
- 2/3/16
- 16/3/16
- 27/3/16
- 25/5/16
- 6/7/16
- 21/9/16

Topics of conversation included:

- Youth Anti-social behaviour

In respect of the youth anti-social behaviour a problem solving meeting was arranged and attended by a number of residents and wide range of partners. A survey had been carried out prior to the meeting to gauge the public views and the results, along with police data, were used to inform the problem solving discussions. Actions arising from the meeting are being overseen by Thatcham Vision including engaging with young people in Thatcham. The Detached Youth Team has been a key partner in seeking a resolution to this problem.

Thatcham Vision has 6 groups and 35 volunteers all working towards priority areas of children, older people, transport, culture & leisure, community safety and population & development.

A Community Development Worker has been appointed by Thatcham Town Council and this post will be key to future developments.

Burghfield and Mortimer

Conversations held on following dates:

- 13/7/16
- 26/9/16

Topics of conversation included:

- Lack of youth club provision
- Proximity to Reading and not feeling part of West Berkshire
- Improving communication through collaboration

The conversations have benefitted from a very proactive Youth Outreach Worker and the lack of youth club provision was one of the concerns raised. It was agreed that any further discussions and planning should be led by young people in the community. Berkshire Youth has agreed to carry out some scoping work.

Concerns were raised about young adults who are 'care leavers' living in their own accommodation who are isolated. The potential for engaging them in the community through involvement with social media was identified along with the idea of their supporting older people with the use of gadgets and mobile phones.

Prior to Christmas 2016 Mortimer St Mary's school was 'open to the community' for a week. A number of residents visited and offers of support captured by this event will form the foundation of the Mortimer Community Plan.

Both of these communities have websites, facebook pages and community publications and benefit from a number of community events throughout the year that raise significant sums of money for charities both local and national.

There is a befriending service which gives anyone who feels alone the chance to have personal face to face contact through coffee mornings, lunch clubs and outings thus addressing social isolation.

5. Additional Community Conversations

5.1 To support St Bart's School engage with the Building Communities Together initiative and to adopt Restorative Practice the Volunteer Centre facilitated 4 school based community conversations on the following dates:

- 20/4/16
- 25/5/16
- 7/6/16
- 28/6/16

6. Action Plans

6.1 To date the issues that have been raised at Community Conversations have not required details action plans in order for them to be addressed.

7. Volunteering Support

7.1 In addition to co-facilitating the Volunteer Centre provides support and advice to anyone who wishes to volunteer be it arising from a community conversation or other activity across West Berkshire. It has been recognised that it is extremely important that if someone steps forward to volunteer that they have a clearly defined role and on going support.

7.2 There are currently approx 110 volunteers engaged with Community Conversations.

8. Young People's Voices

8.1 It has been recognised that it is important to engage with the voices of young people in the Community Conversations and an opportunity has been identified to support this.

8.2 Within West Berkshire secondary schools there is a network of Peer Mentors, who work with primarily Year 7 children who need extra support/guidance. It has been identified that Peer Mentors could potentially be supported in feeding their experiences and views into their local Community Conversations.

8.3 This idea is going to be discussed at a meeting of Peer Mentor Coordinators in February 2017 and consideration is also being given to having Community Conversations on the 'agenda' at the Peer Mentor's annual conference in November 2017.

9. Restorative Practice

9.1 There has been significant investment by West Berkshire Council in adopting Restorative Practice including, in the context of Community Conversations, the training of Community Anchors and a number of Council and Partnership officers in Restorative Practice.

9.2 It will be important to sustain this investment in order that Community Conversation can continue to strive to achieve the stated aim to 'develop a community led restorative approach'.

9.3 In a Restorative Approach context the Building Communities Together initiative seeks to build on the skills, assets and strengths in a community to:

Help people help themselves and help people each other

10. Learning Event and Toolkit

10.1 A Learning Event was held at Newbury Baptist Church on 19th January 2017 and provided an opportunity for Community Anchors and other practitioners to share good practice. Restorative Practice Methodology (a problem solving circle) was used to share and discuss:

- What works well in community conversations
- What to consider in planning a conversation
- How to approach a conversation
- Who to involve
- The scale and range of solutions that can arise

10.2 It is anticipated that this learning will be captured in the development of a Community Conversation Toolkit. It is intended that this resource will be a helpful tool that any community could pick up and used to extend the use of this way of working. It has been proposed that the Toolkit will be brought to the Health and Wellbeing Board for consideration in Spring 2017.

10.3 It was identified by those attending the Learning Event that achieving the vision of change within communities where people feel supported and able to help themselves needs to be long term. It was also acknowledged that this is challenging work that takes time to develop and become embedded.

11. Problem Solving

11.1 At the Learning Event described above there was a presentation from a Thames Valley Police officer on Enhanced SARA Problem Solving. The SARA (scanning, analysis, response, assessment) approach to problem solving has been used by Thames Valley Police for some time and the enhanced model is adaptable to 'problem solve' in a community setting.

11.2 In respect of a Community Conversation this approach was used when an issue with youth anti-social behaviour was identified and a SARA meeting was convened with actions arising. Importantly the Problem Solving meeting was structured utilising Restorative Practice Principles and the community was supported in identifying and owning arising actions.

11.3 This experience demonstrated that by taking a restorative approach to problem solving, utilising the enhanced SARA model, communities can be supported in clearly identifying and understanding a problem, considering appropriate actions and taking ownership of outcomes. Importantly the SARA approach enables identification of other sources of help and input and also enables communities to see that often solutions lie within their own resources.

11.4 Problem solving will be a key aspect of the role of the Building Communities Together Team, consisting of officers from West Berkshire Council and Thames Valley Police.

11.5 The Building Communities Together Team will also have responsibility for further development and coordination of Community Conversations alongside multi agency problem solving.

12. Community Conversation Review Meeting

12.1 This meeting held on 17th January 2017, was convened by the Volunteer Centre and was attended by a range of participants from across all Community Conversations.

12.2 There was an honest exchange of views and ideas throughout the meeting that can be summarised by the following points:

- Community Conversations have been a good networking opportunity for professionals
- Generally residents attending Conversations were already 'active' in their community
- Conversations could feel more 'real' to residents than traditional public consultations
- There needs to be a 'mapping' of community assets
- There isn't any clear structure for the Conversations
- The 5 'Priorities' don't match the 'issues/concerns' raised in the Conversations
- 'Meetings' are 'old hat' – need to communicate on other ways – especially with young people
- Go to where people are already 'talking'
- Professionals need to be able to signpost more efficiently – be more informed

- Need to have the right people at meetings e.g. GP, Council Member, Teacher, Neighbourhood Police Officer, etc.
- Need link things up – websites etc.
- Need to be clear about what the Conversations are seeking to achieve and why people should join in
- Need to try and engage with 'hard to reach – hard to hear' communities
- Communities need to see things change or they will disengage

12.3 These views need to be incorporated into future planning for Community Conversations.

13. Conclusions

13.1 Community Conversations commenced in March 2016 as part of the Building Communities Together Programme.

13.2 Conversations have been co-facilitated by Empowering West Berkshire/Volunteer Centre West Berkshire in 4 of the 5 communities identified.

13.3 The range of issues identified during conversations has been diverse and some community orientated solutions identified.

13.4 Volunteers have been forth coming with approximately 110 currently engaged in Community Conversartions.

13.5 A professional's forum has arisen from one Community Conversation.

13.6 Restorative Approaches and Problem Solving have underpinned the conversations with residents and partner working together to identify issues and solutions.

13.7 Engagement needs to be improved particularly with young people and hard to reach groups/communities.

13.8 Restorative Approaches need to be sustained.

13.9 SARA Problem Solving is a useful tool within Community Conversations.

13.10 Learning from 'review' meetings held in January 2017 should influence future plans.

14. Future development

14.1 The Building Communities Together Team will assume responsibility for the coordination and development of Community Conversations from April 2017.

14.2 It is proposed that the Strategic Priority for 2017/18 is reframed to:

Increase the number of Community Conversations through which local issues are identified and addressed

14.3 It is proposed that the Building Communities Together Team:

- Conduct an audit of Community Conversations currently underway to clarify outputs, outcomes and impacts during 2016/17 and to celebrate success – *May 2017*
- Identify existing community forums and activities that have potential to become 'new' Community Conversations – *September 2017*

- Conduct Community Engagement activities to support the development of 'new' Community Conversations and to identify local community based issues – *March 2018*
- Develop a Project Management Structure for Community Conversations – *June 2017*
- Use data to support individual Community Conversations in identifying issues and, where appropriate, to monitor change - *ongoing*
- Work with the Volunteer Centre West Berkshire to support Community Conversations - *ongoing*
- Produce an Annual Report for the Health and Wellbeing Board – *April 2018*

Appendices

Appendix A – Detailed information on Hungerford Community Conversation

Consultees

Local Stakeholders:

Officers Consulted:

Trade Union:

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Building Community Together

Community Resilience in Action - Hungerford

Context

The Hungerford community conversations have developed to allow a sharing of experience and skill between local residents and multi-agency staff working in Hungerford (everyone from Police Officers, to teachers, early years and family support workers, health visitors, the local library and local charities).

The work has been successful in large part to the skilled and determined leadership of the local Head of Hungerford Nursery School, who has acted as a 'Community Anchor' for the local community conversation, with the active support from other partner agencies.

Building Community Together aims to empower local communities and individuals to find their own sustainable solutions to improve the quality of life locally in Hungerford and reduce the likelihood of residents needing more specialist help later on.

The local community has looked at a number of areas including:

- School transport
- Building a sense of community cohesion
- Helping parents with more challenging home situations to manage and look after their children
- Supporting different professionals with how they can best work together to work together to meet emerging needs early
- Designing innovative approaches to pastoral support and inclusion within Primary and secondary schools
- A local charity working with more vulnerable young people to give them a positive experience of producing a film – the Watermill Community Film Project – to increase their sense of aspiration and achievement and help them make an active and positive contribution to their local community.

Here is a more detailed explanation of two of these areas of local change

Understanding the difference this has made to local residents

Local parents, a number of whom had previously had their children removed into the care system, came together to find ways, with the help of some local professionals, to manage their family and social circumstances. They informed the development of a programme of support led by the local Family & Well-Being Hub, with the help of the Emotional Health Academy.

The programme helped local parents to get a greater sense of confidence and self-worth, by encouraging them to volunteer locally in the community. These parents shared their confidence with other parents in the local area. This experience has provided the experience and confidence for a number of these parents to start to get a job and start to work. It's encouraged other parents locally in the community to ask for help earlier with managing the stresses and strains of their lives. These parents have not been referred back to

Social Care – the strategies they learnt have helped them manage day-to-day much better. The Family and Well-being Hub continues to be a place these parents can come back to, whenever they need a bit of support.

Impact on outcomes

100% of the finishing group had shown improvement in the course outcomes including:

- Awareness of professional boundaries and appropriate behaviours.
- Confidence to contribute positively to group environments.
- Understanding diversity and how to manage it within a group
- Understand how to develop positive working environment using FISH philosophy
- Understand the qualities of reliable, committed volunteer or worker.
- Understanding of working in a restorative way.

At the end of the course of those eight that finished:

- Two had started further training one in child care and one her maths GCSE,
- Three moved into employment of those one is now part of the family centre team, two were pursuing starting their own business
- One is currently waiting to take up a volunteer role at our Lambourn Family Play and learn sessions.

Feedback from the delegates included:

'I feel more confident in myself to recognise people's needs and better at reading people's body language. I will use these skills to hopefully get a job and help others' CB

'*FISH has helped my family because its taught me to try to listen more and to make their day and to reward them even if it's something small' BG*

'I feel more confident especially when it comes to my new place of employment. I have a the ability to talk to people and support where needed' KB

A professional perspective – building professional resilience and real partnership

At the request of local workers from a range of organisations in the area, a multi-agency model of restorative supervision and reflection was introduced, helping staff from very different professional backgrounds to come together to talk about the local challenges they were struggling to improve and problem solve together. This group very quickly begun to support improved joint working, consistent descriptions of the type of need or risk professionals were trying to manage and introduced a more consistent approach to working together to solve problems.

Multi-agency professionals say that the difference includes:

- it's reduced their feelings of professional anxiety
- their actions are far more proactive, rather than reactive – they try and solve the problem, rather than react to the problem
- they look together for what is 'causing' a problem or behavior and try and fix the cause, rather than just reacting to the problem or situation
- they feel as though they are managing risk or challenge together with others, rather than on their own – they are less isolated.

'I firmly believe that multi-agency work is a very strong vehicle for supporting families, sharing concerns and developing solutions which would otherwise be a huge burden on individuals. It is not about 'doing onto others' and is most often about helping families to help themselves. The guidance, advice and signposting of colleagues from other agencies brings a greater depth to finding pathways to support and it is invaluable'

Primary School Head Teacher

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Health and Wellbeing Board Strategic Action Plan 30 March 2017

Strategic Aim: Build a thriving and sustainable environment in which communities can flourish

Strategic Objective (2017/18 Priority)	Overall performance
Increase the number of Community Conversations through which local issues are identified and addressed	RAG

Ref	Action	Owner	Date due	RAG	Narrative
	Conduct an audit of Community Conversations currently underway to clarify outputs, outcomes and impacts during 2016/17 and to celebrate success - May 2017	BCT Partnership/ Susan Powell	May-17		
	Identify existing community forums and activities that have potential to become 'new' Community Conversations - September 2017	BCT Partnership/ Susan Powell	Sep-17		
	Conduct Community Engagement activities to support the development of 'new' Community Conversations and to identify local community based issues - March 2018	BCT Partnership/ Susan Powell	Mar-18		
	Develop a Project Management Structure for Community Conversations - June 2017	BCT Partnership/ Susan Powell	Jun-17		
	Use data to support individual Community Conversations in identifying issues and, where, appropriate, to monitor change - ongoing	BCT Partnership/ Susan Powell	Ongoing		

Health and Wellbeing Board Strategic Action Plan 30 March 2017

Strategic Aim: Build a thriving and sustainable environment in which communities can flourish

Strategic Objective (2017/18 Priority)	Overall performance
Increase the number of Community Conversations through which local issues are identified and addressed	RAG

Ref	Measures	Owner	Target	RAG	Narrative
	Number of identified Communities that have started new Community Conversations	BCT Partnership/ Susan Powell	10 (Mar-18)		
	% of identified communities that have mapped their assets within 3 months of identifying this as a requirement	BCT Partnership/ Susan Powell	100% (Mar-18)		
	% of identified communities that have been trained in problem solving methodology	BCT Partnership/ Susan Powell	100% (Mar-18)		
	% of identified communities that have agreed what actions will be undertaken to address locally identified issues	BCT Partnership/ Susan Powell	100% (Mar-18)		

Title of Report:	**Update on Alcohol Harm Reduction Partnership Activities**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	30 March 2017

Purpose of Report: **To inform the board of current activities and future intentions**

Recommended Action: **To review and return comment to the Alcohol Harm Reduction Partnership (AHRP)**

Reason for decision to be taken: So that the Health and Wellbeing Board can be assured of activity being undertaken against its area of focus for 2017.

Other options considered: n/a

Key background documentation: Reducing barriers to treatment through collaboration and engagement in West Berkshire

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Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?		x
• Is it a major policy, significantly affecting how functions are delivered?		x
• Will the policy have a significant impact on how other organisations operate in terms of equality?		X
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?		x
• Does the policy relate to an area with known inequalities?	x	
Outcome (Where one or more 'Yes' boxes are ticked, the item is relevant to equality)		
Relevant to equality - Complete an EIA available at www.westberks.gov.uk/eia		☐
Not relevant to equality		☐

Executive Report

1. Introduction

1.1 The Health and Wellbeing Board determined that reducing alcohol related harm would be a priority for 2017 within the Health and Wellbeing Strategy. The Board expressed its intention to make measurable progress to reduce alcohol related harm over a 12 month period.

1.2 In order to help the Health and Wellbeing Board and other key community stakeholders gain a greater understanding of current services available to reduce alcohol related harm in West Berkshire an Alcohol Hot Focus session was run on October 27th from 09.30am till 12.30pm at the Council Offices in Market Street, Newbury.

1.3 The session also sought to demonstrate how it would be possible to achieve the Health and Wellbeing strategic objective of reducing alcohol related harm and what steps would need to be taken.

1.4 Attendees were asked to self select to be part of a task and finish group .This group would develop terms of reference and develop an action plan for the next year. The first meeting was set for 15th November 2016.

2. Alcohol Harm Reduction Partnership

2.1 The task and finish group became the Alcohol Harm Reduction Partnership (AHRP) as it was felt that the partnership needed to look at future ways of joint working. It has met on three occasions since the Hot Focus event and has agreed its membership and terms of reference. The membership of the AHRP includes a mix of Council services, Health, Police, voluntary sector reps, charities and service providers.

2.2 The initial work of the AHRP has been around completing the CLeaR tool, which aims to bring together all those working to reduce alcohol-related harm in a locality to think through what is working well and to identify the opportunities for further improvement. The outcome of the assessment was that West Berkshire as a locality has average performance and performs below the national average on a number of measures. The outcomes of the self-assessment have informed the AHRP's action plan for 2017 and its medium term objectives.

2.3 Two projects have been identified which can be implemented and completed within 12 months, in order to demonstrate measurable progress against reducing alcohol related harm . These are the Blue Light Project and the Identification and Brief Advice (IBA) training project.

3. Blue Light Project

3.1 Alcohol specific mortality is not falling and while West Berkshire is below the national average, its performance is rated as amber (warning). There are 46 people in West Berkshire who are long-term alcohol dependent and are highly likely to have been expensive to services.

3.2 The Blue Light project is Alcohol Concern's national initiative to develop alternative approaches and care pathways for treatment resistant drinkers who place a burden on public services. It is supported by Public Health England and 23 local authorities across the country.

3.3 Drawing on both motivational and harm reduction approaches it provides non-specialist and specialist workers with tools they can use and pathways they can follow which help to manage the risk and directly reduce associated problems such as domestic abuse, fire deaths and health problems.

3.4 Swanswell Drug and Alcohol Service have a national record of delivering the Blue Light Project. They have already expressed an interest in delivering the project in West Berkshire, taking a multi agency approach and coordinating via an operational group.

3.5 It is proposed that the Council's Public Health service, on behalf of the AHRP, commissions Swanwell to deliver the Blue Light Project in West Berkshire. The Board will be presented with the project plan once it has been developed.

4. Identification and Brief Advice (IBA)

4.1 Identification and Brief Advice (IBA) is an alcohol brief intervention which typically involves:

(1) **Identification**: using a validated screening tool to identify 'risky' drinking.

(2) **Brief Advice**: the delivery of short, structured 'brief advice' aimed at encouraging a risky drinker to reduce their consumption to lower risk levels

4.2 IBA can be initiated by front line health and social care roles wherever they have a good opportunity. It is prevention rather than a treatment approach to helping at-risk drinkers make an informed choice about their drinking.

4.3 IBA is essentially the delivery of short simple brief advice following Identification (i.e. screening) not usually lasting longer than 5-10 minutes. Extended 'brief intervention' approaches may last around 20 minutes and integrate brief motivational interviewing techniques.

4.4 IBA is intended for risky drinkers – those who drink at increasing or higher risk levels but are not alcohol dependent

4.5 IBA can be delivered via commissioned training or adopting a train the trainer model. The Council's Public Health service, on behalf of the AHRP, will lead commissioning discussions with IBA to roll out a package of training with selected front line practitioners.

5. Medium and Long Term Objectives

5.1 The CLeaR tool has also lead to the identification of medium and longer term objectives, to be included in the AHRP's strategic action plan:

(1) Formation of cross sector Alcohol Harm Reduction partnership **(completed).**

(2) Completion of Alcohol CleaR assessment tool by all partner agencies. **(completed).**

(3) Share the draft Alcohol Strategy shared with the Health and Wellbeing Board for comments and adoption.

(4) Form a young people's subgroup to update the Young People's Harm Reduction Strategy, considering both direct and indirect harm. Share the draft Strategy with Local Children's Safeguarding Board and HWBB for comments and adoption.

(5) Ask Health & Wellbeing Board and STP Board to lobby parliament for minimum price per unit.

(6) Commission delivery of Alcohol Identification and Brief Advise training for both clinical and non-clinical staff. **(To be completed by end of 2017)**

(7) Explore if West Berkshire can be a member of Community Alcohol Partnership (CAP) in order to apply for funding for alcohol education.

(8) Ensure AHRP campaigns form part of the H&W Board's Communication strategy.

(9) Promote sustained recovery through recovery community service in Swanswell.

(10) Explore the demand for interventions around treatment resistive people.

6. Equalities Impact Assessment Outcomes

6.1 Due consideration of the inequalities facing this group will be considered in the planning and implementation of the projects described above, both of which will have clear guidance on managing any equality issues that may arise.

7. Conclusion

7.1 If the Board agrees with the proposed projects the AHRP will move forward with commissioning them with a view to completing both within a 12 month period. The Board will receive regular updates regarding the progress of the projects and will provide an evaluation report upon completion.

Appendices

Appendix A - Reducing Alcohol related harm, Reducing barriers to treatment through collaboration and engagement in West Berkshire
Appendix B – Slides from presentation to AHRP

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Reducing Alcohol related harm
Reducing barriers to treatment through collaboration and engagement in West Berkshire

Background

Swanswell have delivered the Blue light project since its inception and in fact were one of the contributors/sponsors for the original project. During this process, we have learnt an incredible amount and we continue to look at different ways to engage those who are reluctant and not ready. We support colleagues across services to manage and mitigate risk these service users and those close to them and the wider community experience.

We currently use the Blue Light Manual, which contains:

- Tools for understanding why clients may not engage
- Risk assessment tools which are appropriate for drinkers
- Harm reduction techniques workers can use
- Advice on crucial nutritional approaches which can reduce alcohol related harm
- Questions to help non-clinicians identify potential serious health problems and deliver enhanced personalised education
- Management frameworks
- Guidance on legal frameworks

We want to build on this work in West Berkshire to create a multi- agency response that is co-ordinated by Swanswell through an operation group.

The client group and the local burden

- At any one time the vast majority of problem drinkers are not engaged in a process of change. Public Health England has suggested that 75% of dependent and higher risk drinkers are not engaged with services (Blue light manual)
- Swanswell services cannot provide an assertive response to meet all of this large group of people's needs. However, this is a group of people which contains some of the most risky and vulnerable members of our community. Many are the focus of concern to the health, social care and criminal justice system e.g. the frequent attendees in the hospital system, the perpetrator of anti-social behaviour, the nuisance 999 caller and the repeated arrestee. Additional resources will be needed to fulfil this element.

We will undertake:

- Two initiatives which will support this whole group of clients; &
- A more intensive initiative targeted at a small group of the highest risk clients

Targeting all change resistant clients

We will:

- Ensure the roll out of alcohol Identification and Brief Advice to as many frontline staff as possible but enhance this with inputs on what to do with people who reject change;
- Provide more in-depth training courses on working with change resistant drinkers
- Provide independent reviews of those individuals in treatment who continue to be resistant to change

Targeting the highest risk drinkers
An intensive response cannot be offered to the vast number of drinkers who make up the 94% who are not engaging. Alcohol Identification and Brief Advice (ABI) and the offer of services are a reasonable approach to a large swathe of these drinkers. However, a small group require a more targeted approach. Making this work will require clear agreement on a definition of the group to be targeted.

At the heart of this process will be a multi-agency group which meets at least monthly. This will have core membership of:

- Swanswell
- Police
- Hospital
- Probation
- Local authority

This membership could also include, as necessary:

- Ambulance / Fire Service
- Housing
- Primary care

1. **Process**

The group will jointly agree the local high volume / high risk service users with alcohol problems who require a more intensive response.

The partner agencies will ensure relevant staff are aware that when such a service user is identified a specific response is required i.e.:

- Signed permission will be sought for Swanswell to make contact.
- Swanswell will require the provision of relevant risk information.
- Positive encouragement will be given to promote client self-belief.
- Harm reduction and risk management advice will be given.
- Feedback will be required for the next multi-agency meeting.

Where appropriate Swanswell will engage other agencies to support their work. This involvement should be agreed wherever possible, e.g. the ambulance service jointly visiting a client.

If consent is secured, Swanswell should be contacted to ensure a swift response.

- Swanswell will offer an assertive response including a swift appointment, a home visit or a meeting at a convenient location.
- Wherever possible the referring agency should be willing to undertake an initial joint visit.
- Swanswell will make assertive efforts to reduce risk and harm and engage the person into service.
- Partner agencies will work in concert by reinforcing messages to the person about harm reduction and encouraging change.
- All agencies involved with the person will report back to the monthly meeting on progress and next steps

If consent is not secured, the multi-agency meeting will ensure that agency staff continue to seek opportunities to engage and the group will consider alternative approaches e.g.

- Barriers which may be preventing engagement in services.
- Alternative approaches to engaging the person.

- Other local resources, such as faith groups, which could be utilised to work with the individual.
- Involving family members.
- Identifying incentives to engage the person in treatment.
- The possible use of compulsory powers.

In some cases this group will be responsible for identifying, recording and reporting unmet need to commissioners.

Measuring the impact
The impact targets for this work are very straightforward and will encompass output and outcome targets.

Output: The number of clients identified by the multi-agency group who are engaged and the period of engagement
Outcome: The reduction in the behaviours which had brought the client to the attention of the multi-agency group e.g. hospital attendances, arrests, 999 calls etc.

The outcome target will be to reduce the cost burdens presented by the clients meeting the definition and brought to the multi-agency group by 20% per annum.

As part of the service delivery Swanswell will undertake the following:

GP Liaison
To support GP in identifying appropriate referrals and encourage partnership working and signposting to appropriate services
Help primary care practices to identify those who have alcohol related issues and review with the practice each individual and together create a plan

Monitor with the practice the progress against plan. This is an intensive piece of work and we would suggest supporting 1 practice per quarter.

Outreach/Home Visits
Assessing, and engaging, the needs of those who have failed to engage with services and fulfil the requirement above. This will be achieved through an outreach capacity and linking in with partner agencies to conduct joint home visits with the aim to integrate the individual into appropriate services.

Hospital Liaison/Triage/ A+E Admissions
Linking in with hospital alcohol nurses in Basingstoke and Swindon and working alongside the RBH in identifying frequent flyers so to coordinate and plan an approach to a+e admissions. Part of this work will be underpinned through educating hospital staff on the service and referral pathways, creating Joint Working Protocols (JWP)to ensure Swanswell are able to 'catch' individuals when in hospital so that the optimum time for engagement is not missed.

Ambulance
Strengthening referral pathways when ambulances are called out to a person who may meet the criteria. Establish JWP to share data on attendances to area/addresses so to better inform service provision plans and identify needs of local area

Police

Strengthening referral pathways when the Police are called out to a person who may meet the criteria of the service. Establishing JWP to share data on attendances to area/addresses so to better inform service provision plans and identify needs of local area.

Housing
Working with local housing services including WBC ASB department and identifying those who may need benefit from the service, this may be through those at risk of eviction.

Swanswell Nurse
Working in close partnership, offering alcohol assessment and identifying suitable community and in-patient detox candidates.

Mental Health and Adult Social Care
Working in partnership to up skill staff to take an innovative/person centred care plan approach to working with treatment resistant drinkers, including supporting to identifying appropriate services.

Swanswell will provide IBA and optional motivational interviewing training and IBA plus training for partner organisations and GP practices who support those who historically have not engaged or regularly drop out of service. Pathways will be developed with the following organisations.

Other Services where support will be offered

- **SEAP Advocacy Service**
  Mental health advocacy service
- **Age Concern**
- **Community Groups**
- **Bereavement Services**
  We imagine there will be an aging population who may amongst other reasons, drink due to loneliness.

- **Domestic Abuse Services/ Perpertrator Services**
  There is strong evidence to suggest close links between DV and Alcohol Use
- **Florey Unit Contraceptive Outreach Nurse**
  Poppy Team Specialist Midwife
- **CAB**
- **LGBT Services/Groups**
- **Mutual Aid**
  Including linking into AA sponsor network

Background statistics in West Berkshire.
The Blue Light Costing - West Berkshire sourced from Alcohol Concern Data

The number of dependent and higher risk drinkers not engaged with treatment:

	Population (2011 census data)	Dependent drinkers	94% not engaging	Higher risk	85% not engaging
West Berkshire	153,822	4,969	4,670	5,138	4,367

Estimates of the cost burden:
This data applies the data in section 7 - the Blue Light costing - to the local partner areas to give a calculation of the local cost of this client group. The data is adjusted by population and the regional level of need. The latter is calculated by calculating the percentage that the regional rate of male and female alcohol specific mortality and hospital admissions is of the national average and then using this percentage as a multiplier to increase or reduce the local rate. The percentages are included at appendix 2.

Service area	Cost of Blue Light clients
Primary care	£316,470
Emergency department	£45,472
Hospital	£292,486
Ambulance	£186,021
Alcohol services	£95,081
Mental health services	£2,808,792
Police	£626,755
Probation	£95,174
Anti-social behaviour services	£789,247
Adult social services	£684,138
Children and families services	£1,511,873
Housing and homelessness services	£98,517
Fire service call outs	£6,593
Fire service false alarms	£4,782
Total	£7,561,401

Estimate of number of Blue Light clients:
This table applies the data in section 8 - the estimate of the number of Blue Light clients - to the local partner areas to give a calculation of the local cost of this client group. The data is adjusted by population and the regional level of need as explained in the table above.

Service area	Estimate of number of Blue Light clients
Primary care	26
Emergency department	26
Hospital	26
Mental health	16
Police	12
Probation	19
MAPPA	2
MARAC	28
Anti-social behaviour	7
Adult social services	35
Children and families social services	56
Housing and homelessness services	6
Street drinkers	21

The total number of clients identified in this table is just over 280. The estimates have been cautious and erred on the lower sider. However, some of these will be the same person counted twice. This suggests that 150 individuals is a realistic baseline estimate.

Dual diagnosis:
A significant proportion of problem drinkers will also have a mental health problem. This combination is associated with high levels of suicide, self-harm and violence to others and makes clients difficult to engage in services or treat effectively. Data from the North East Public Health Observatory provides a picture of the level of mental health need in each area borough.[i] This data can be used to provide an estimate of the numbers with a dual diagnosis.

National Statistics estimates that 27% of respondents in a study of people with mental disorder had an AUDIT score of 8 or more (increasing risk or higher) including 14% who were classified as alcohol dependent.

LA name	Any neurotic disorder	Dependent drinkers (14%)	Depressive episode	Dependent drinkers (14%)
West Berkshire	12,878	1,803	1,809	253
	Secondary MH services	Dependent drinkers (14%)	On CPA	Dependent drinkers (14%)
	237	33	249	35

Impact of dementia on this client group

A sub theme of this project has been the impact of early stage alcohol-related brain damage or injury as a factor in reducing the ability or willingness to engage with change. Ken Wilson's paper *Alcohol related brain damage in the 21st century* has highlighted the potential scale of the unrecognised impact of this condition on dependent drinkers. His work estimates that:

- 35% of dependent drinkers would be diagnosed post mortem with ARBD
- 16% could be clinically identified with ARBD while alive

	Population (2011 census data)	**Dependent drinkers**	**35% of dependent drinkers would be diagnosed at post mortem with ARBD**	**16% of dependent drinkers could be clinically diagnosed with ARBD while alive**
West Berkshire	153,822	4,969	1,739	795

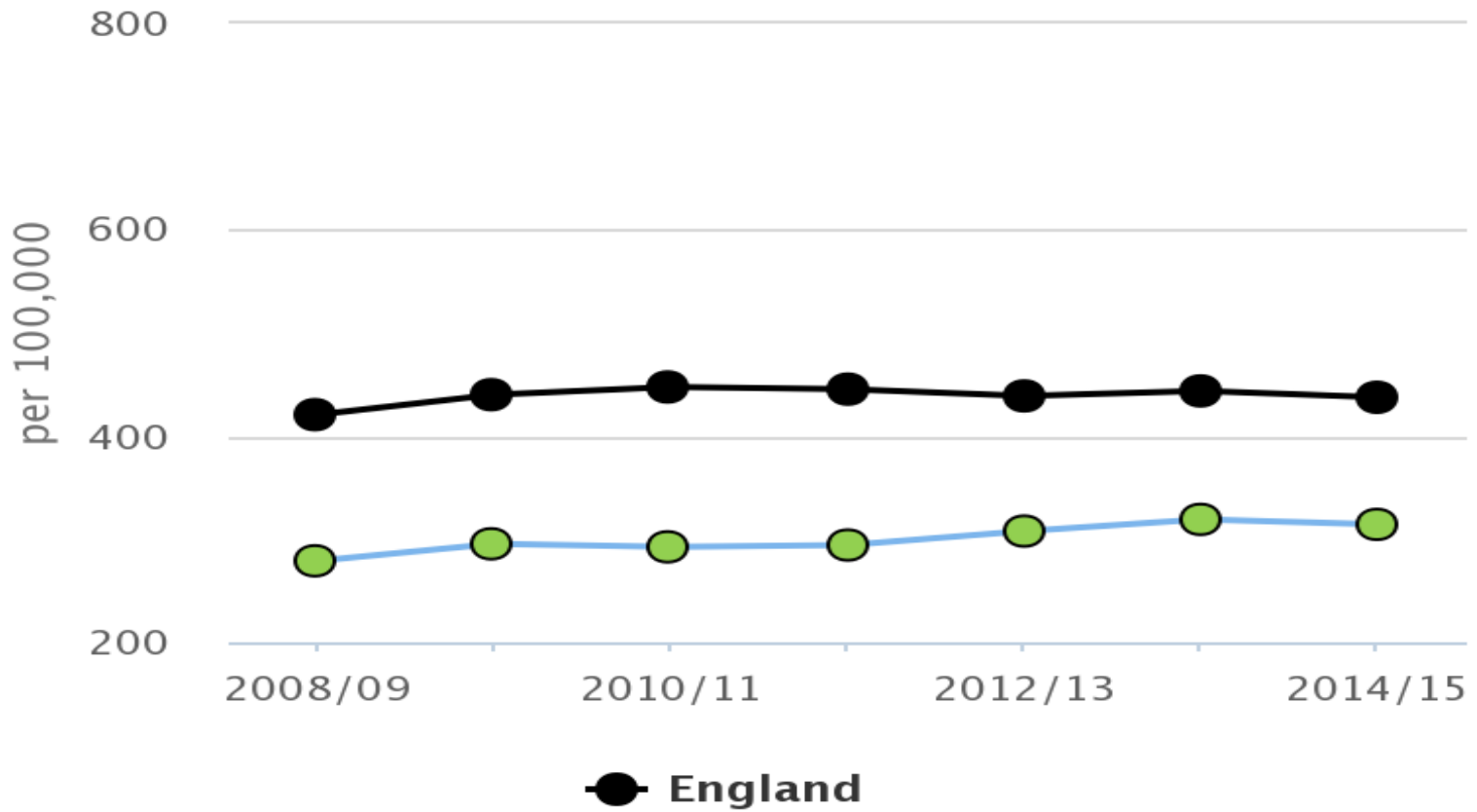
Results Alcohol CleaR tool

Debi Joyce

22nd February 2017

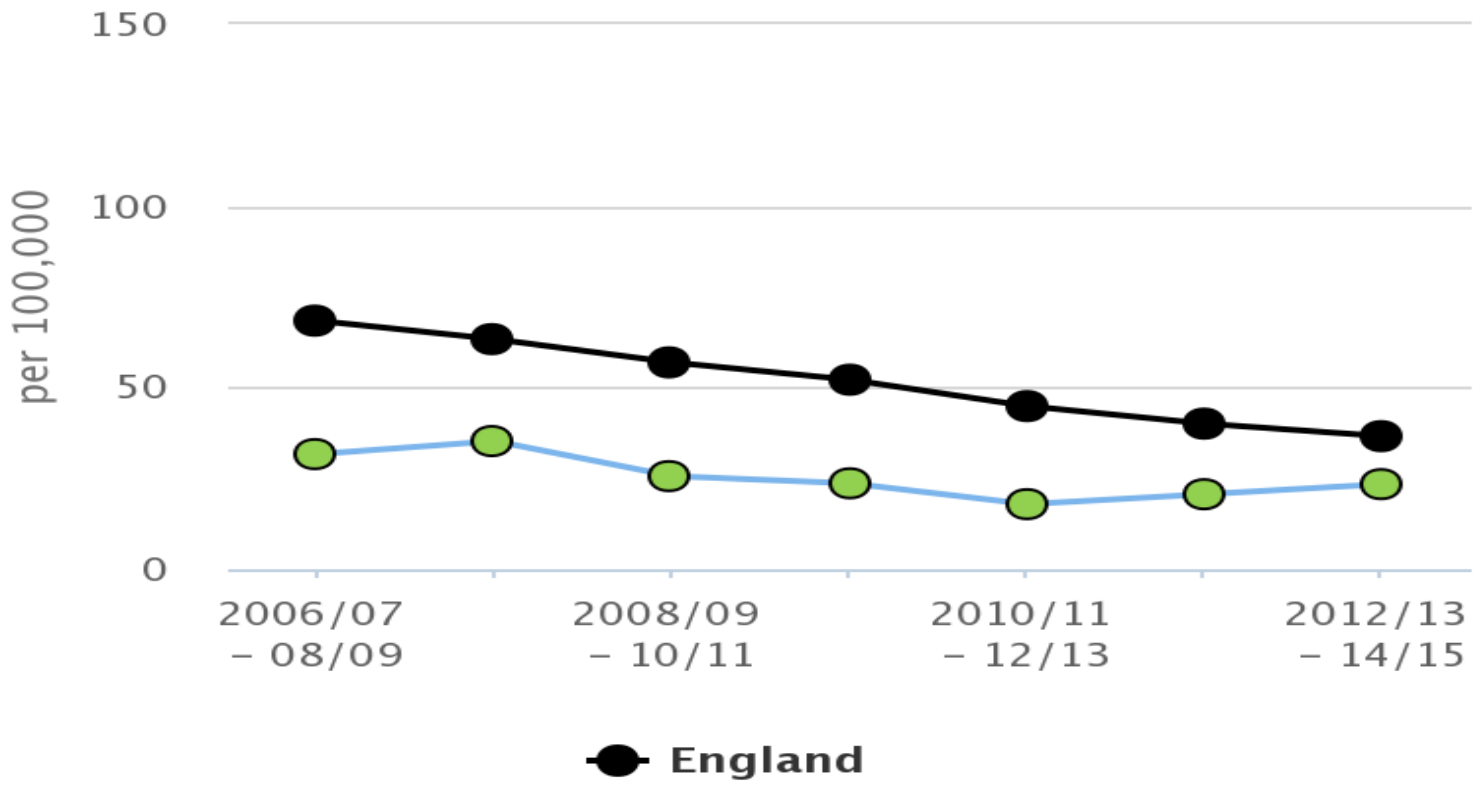
West Berkshire COUNCIL

8.01 – Persons admitted to hospital for alcohol-related conditions (Narrow) (Persons) – West Berkshire

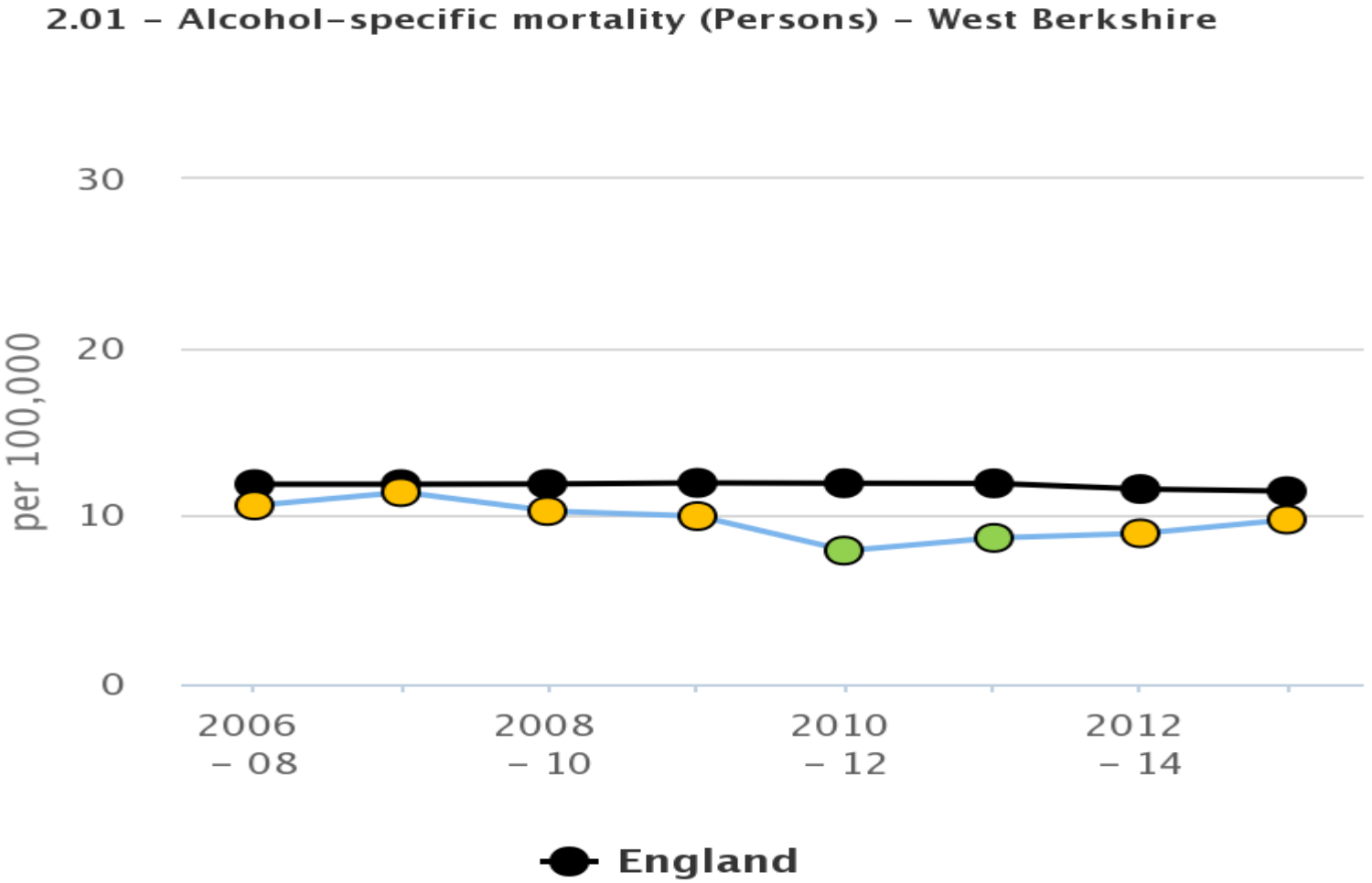


WB (Count=465) rate 314 per 100,000/ wok (count=437) rate 219
Eng rate 438 per100,00

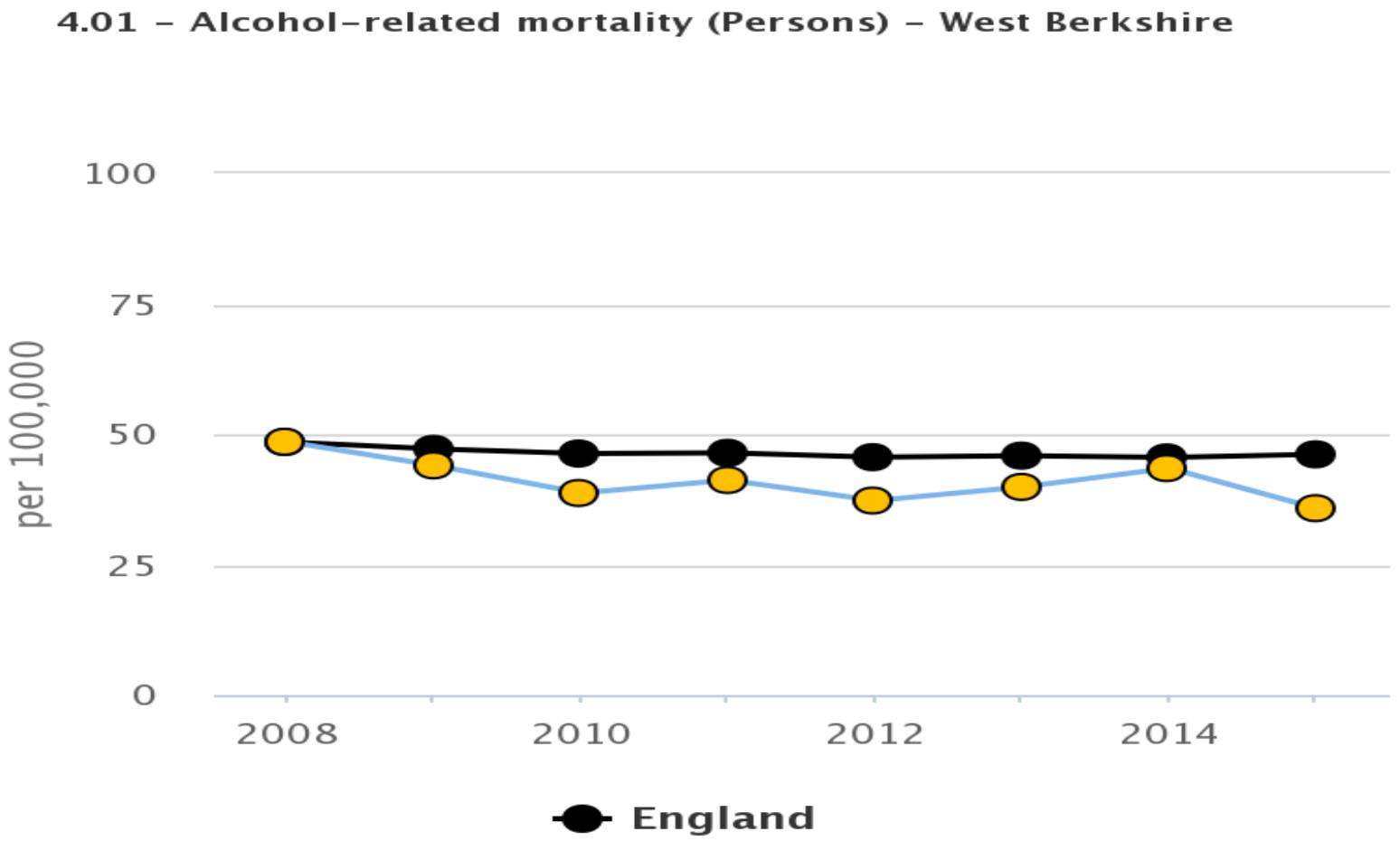
5.01 – Persons under 18 admitted to hospital for alcohol-specific conditions – West Berkshire



WB Count=25 people rate 23.4 per 100,000/wok count=22 Rate 20.1
Eng rate 35.6

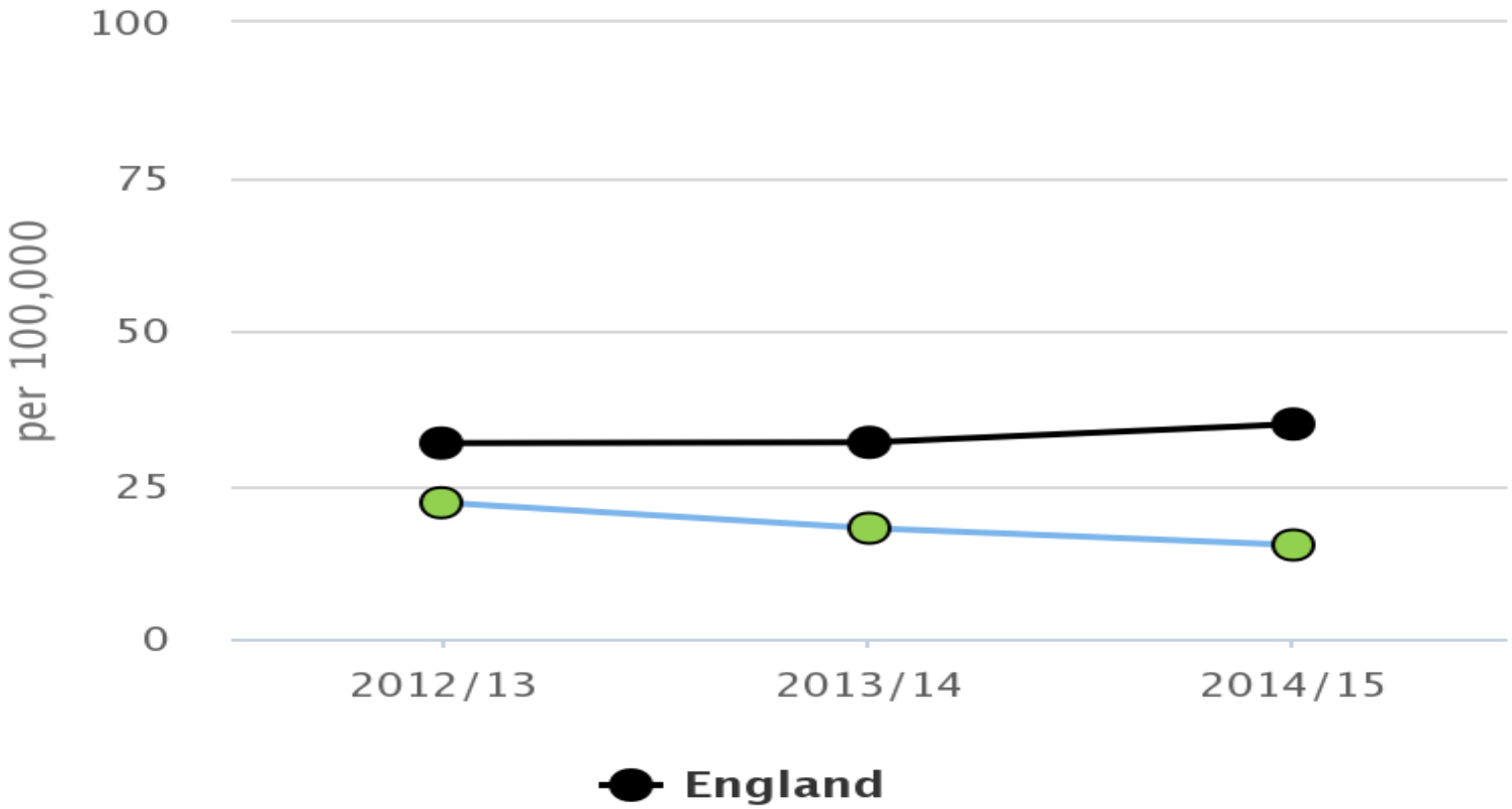


2013-15 rolling WB (count 46) rate 9.8 per100,00/ Wok (count25) 5.5
England rate 11.5

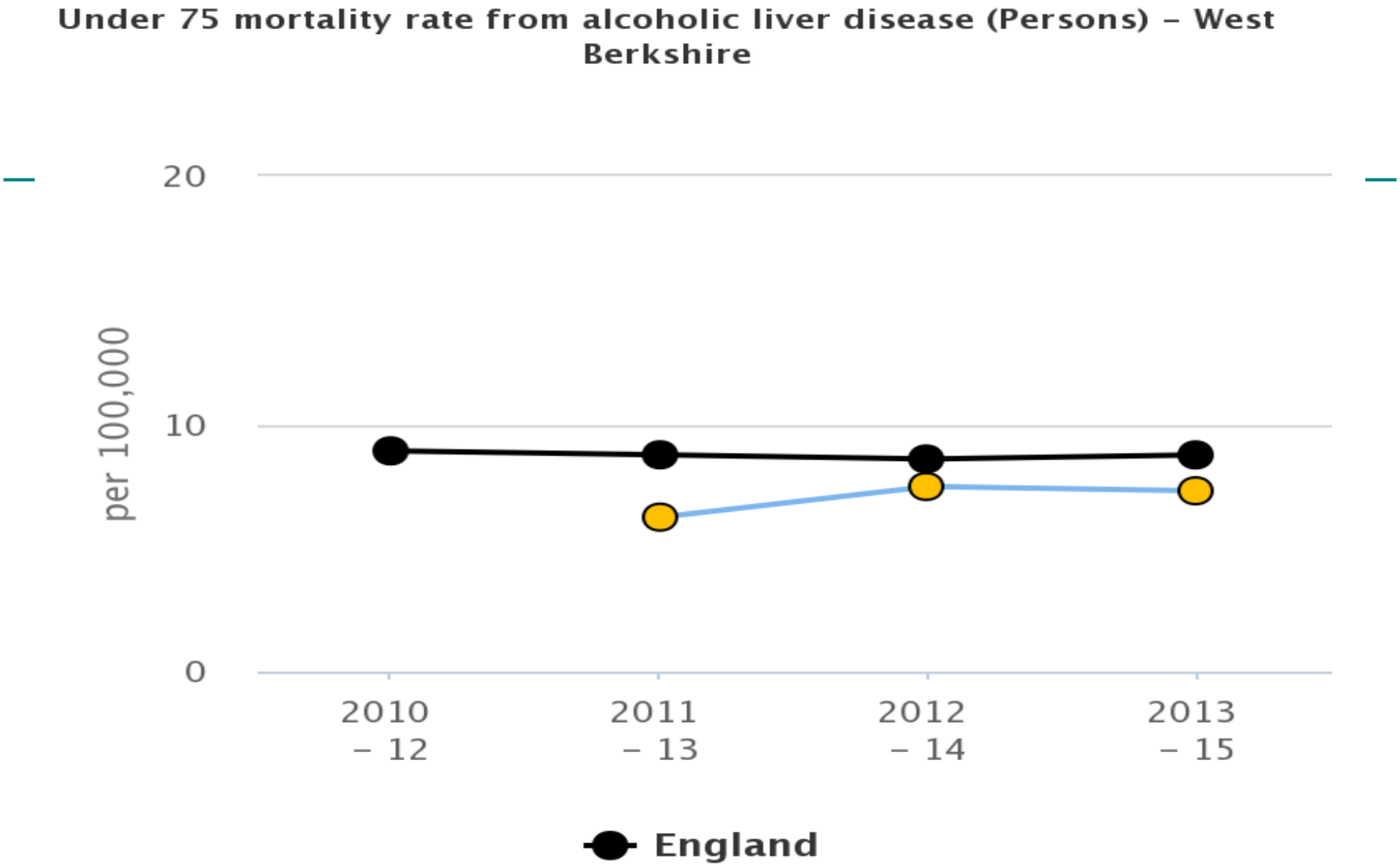


WB (Count =53) rate 35.8 per100,000 Wok (count=58) rate 39.3 England rate 46.1

Hospital admission rate for alcoholic liver disease (Persons) – West Berkshire



WB (Count =24) rate 15.2 per 100,000/ wok (count=30) rate 19 Eng 34.8

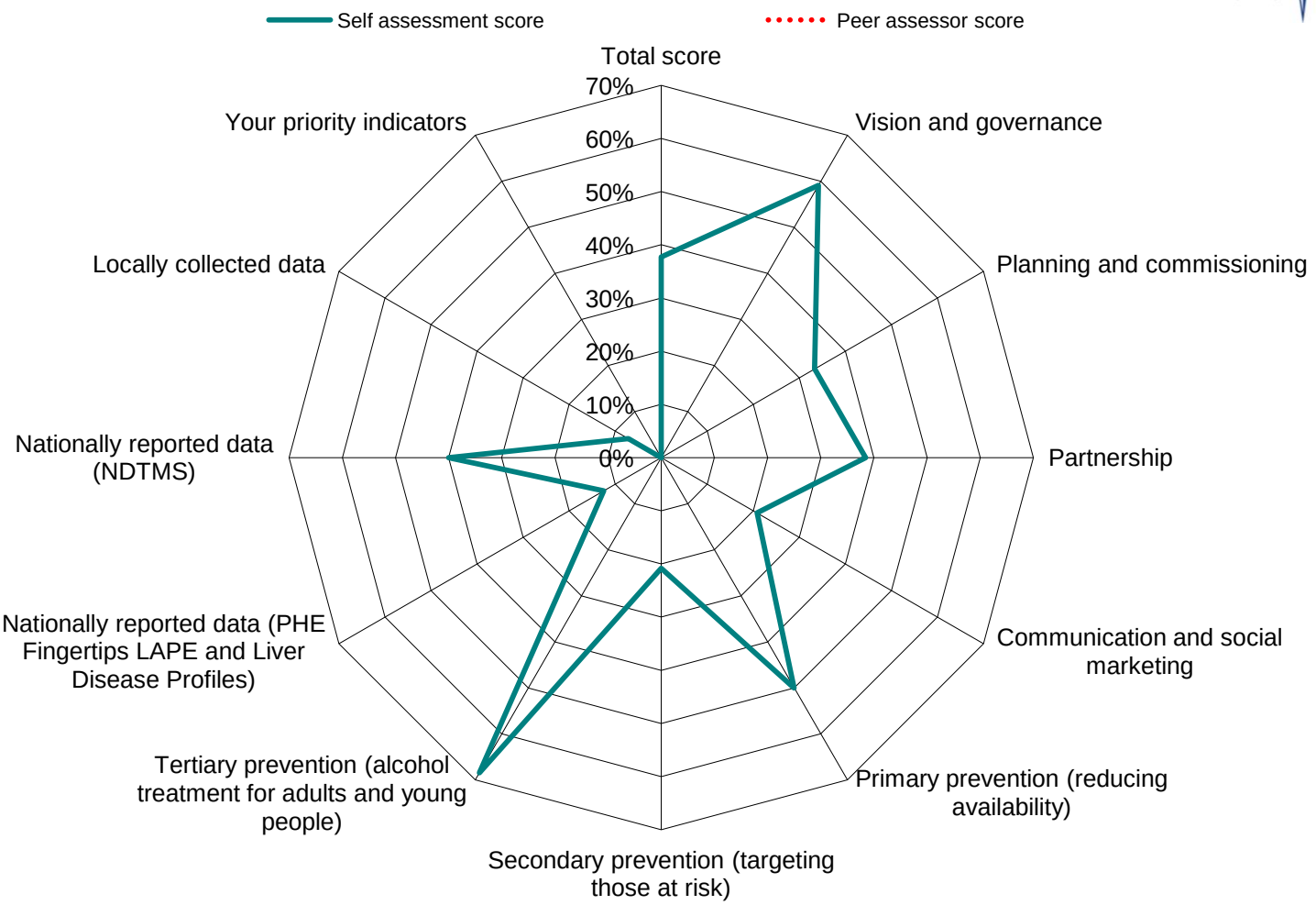


WB (Count 32) rate 7.2 per 100,000/eng 8.7 Wok no data/Eng 8.7

Successful competitions'

	Baseline period		D.O.T	Latest period	
	(%)	(n)	B	(%)	(n)
Opiate	**6.4%**	14 / 219	▼	**5.0%**	11 / 218
Non-opiate only	**30.6%**	11 / 36	▲	**51.3%**	20 / 39
Alcohol only	**46.6%**	48 / 103	▼	**42.7%**	38 / 89
Alcohol and non-opiate only	**52.0%**	13 / 25	▼	**21.7%**	5 / 23

CLeaR profile



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Title of Report:	**The Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP)**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	30 March 2017

Purpose of Report:

To provide the Health and Wellbeing Board with information about the BOB STP.

Recommended Action:

The Board note the report.

Reason for decision to be taken: To comply with the NHS Five Year Forward View

Other options considered: n/a

Key background documentation: n/a

Contact Officer Details	
Name:	Cathy Winfield
Job Title:	Chief Officer, Berkshire West CCGs
Tel. No.:	0118 982 2732
E-mail Address:	cathywinfield@nhs.net

Executive Summary

1. Introduction

1.1 The Health and Wellbeing Board last received information regarding the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP) at its meeting on 24th November 2016.

1.2 It was outlined at this meeting that the final submission of the plan would be made publically available in January 2017.

2. Proposals

2.1 The full proposals of the Bob STP are outlined in the full report at Appendix.

3. Equalities Impact Assessment Outcomes

3.1 The full report outlines any implications for equalities.

4. Conclusion

4.1 The Board is requested to note the final BOB STP submission.

Appendices

Appendix A - The Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Plan (STP) 2016

Consultees

Local Stakeholders: BW10 Integration Board,

Officers Consulted: n/a

Trade Union: n/a

The Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan

2016

Contents of our report

What is the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan?

1

The Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Plan (STP) is one of 44 local plans being developed across England, which will set out how affordable, good quality health and social care will be provided in the future.

The vision for the NHS is clearly set out in a national document called the Five Year Forward View (www.england.nhs.uk/ourwork/futurenhs) and our STP will show how we will deliver this locally.

The Five Year Forward View vision will be achieved by everyone who has a stake in health and care adapting what they do, how they think, and how they act – at both local and national levels.

As part of this, there is a growing consensus that one of the most powerful ways to achieve change is through local health and care services working together - across entire communities and pathways of care - to find ways to close the gaps between where we are now, and where we need to be in the future.

However, this is no easy task and the Buckinghamshire, Oxfordshire and Berkshire West STP is still at the very early stages of development. We have a draft plan which we submitted to NHS England at the end of October 2016 as required, and we anticipate making significant improvements to that plan over the next couple of months.

This is a summary of the main issues we will address in our STP, which covers a population of 1.8 million and has a budget of £2.5 billion. The seven NHS clinical commissioning groups who buy and pay for NHS services, the six NHS trusts who provide health and some care services, and the 14 local authorities who buy social care services, have worked, and will continue to work together to improve people's health, provide better health and care services and improve efficiency.

Why do we need a Sustainability and Transformation Plan?

2

There are a number of challenges facing the NHS that require us to change and modernise the way in which we provide local health and care services to ensure local communities are the healthiest they can be.

There have been some big improvements in health and social care in Buckinghamshire, Oxfordshire and Berkshire West in the last ten years. People with cancer and heart conditions are experiencing better care and living longer, and people are more satisfied with their health and care services. For example, we have some of the best quality and highly regarded general practice services in the country. However, our population is growing rapidly, people's needs are changing, new treatments and technologies are being developed, the quality of care is sometimes variable, and we can do more to prevent illness. Our ambition is to be the best in everything that we do.

Over the next five years, we face the following particular challenges across our area:

- Significant increases in population due to new housing growth
- Pockets of deprivation where communities are not as healthy as they could be
- An increase in demand for services, especially for frail older people who often have more than one health and care need
- Difficulty in recruiting and retaining staff due to the high cost of living, which leads to inconsistent levels of care and unsustainable services
- Ageing NHS buildings which are not fit for modern use
- Variable access to some specialised services and other treatments
- People having to travel out of our area for specialised mental health care.

More money has been provided for the NHS, but we still estimate a gap of around £480 million in the next four years if we do nothing to help people stay healthy and modernise our services. We need to find new and better ways to meet the health and care needs of local people and do things more efficiently. This does not mean doing less for people or reducing the quality of care, but we have to provide services differently in the right place at the right time at the right cost.

How have our plans been developed?

3

We can only make improvements if we all work together. This means patients, their carers, our staff, hospitals, local councils, the NHS, universities, and a range of other organisations working in the public, private and voluntary sectors, all joining together to agree a plan to improve local health and care services in Buckinghamshire, Oxfordshire and Berkshire West.

Our plan has been developed using your feedback from local engagement activities, such as 'Your Community, Your Care' in Buckinghamshire, the 'Big Conversation' in Oxfordshire and 'Call to Action' events in Berkshire West. This engagement will continue and take place in local communities and be led by local organisations.

We have also used feedback and insights from our clinicians and staff. The Oxford Academic Health Sciences Network, which is a local partnership of NHS organisations, universities and life science companies responsible for improving health and prosperity across the region, plays an important role in helping us to work together to improve and modernise treatment and care, as well as helping our region become a better place to live and work.

What are we going to do?

4

Our ambition is to make sure that everyone in Buckinghamshire, Oxfordshire and Berkshire West has access to high quality health and care, regardless of where they live or which service they use.

Care should flow seamlessly from one service to the next so people don't have to tell their story twice to the various people caring for them, and health professionals should be working on a shared plan for each patient's care. Health and care services should also be available when people need it. We want these services to be available closer to home – a stay in hospital should be less frequent because health and care professionals are offering care and treatment at home, or in local clinics.

We have a number of priority areas where we know that by working together we can make a greater difference for patients in terms of improving their health and ensuring they have access to high quality, cost effective care. These priorities are:

- Improving the wellbeing of local people by helping them to stay healthy, manage their own care and identify health problems earlier
- Organising urgent and emergency care so that people are directed to the right services for treatment, such as the local pharmacy or a hospital accident and emergency department for more serious and life threatening illnesses
- Improving hospital services, for example making sure that maternity services can cope with the expected rise in births
- Enhancing the range of specialised services, such as cancer, and supporting Oxford University Hospitals NHS Foundation Trust as a centre of excellence to provide more expert services in the region
- Developing mental health services, including low and medium secure services, more specialised services for children and teenagers, and improving care for military veterans and services for mums and babies
- Integrating health and care services by bringing together health and social care staff in neighbourhoods to organise treatment and care for patients
- Working with general practice to make sure it is central to delivering and developing new ways of providing services in local areas
- Ensuring that the amount of money spent on management and administration is kept to a minimum so that more money can be invested in health and care services for local communities
- Developing our workforce, improving recruitment and increasing staff retention by developing new roles for proposed service models
- Using new technology so patients and their carers can access their medical record online and are supported to take greater responsibility for their health.

What does this mean for local people?

5

As we implement these plans over the next five years we aim to deliver the following benefits to our population:

- People will be able to get an appointment with their doctor at a convenient time
- Specialist and family doctors, community nurses, occupational therapists, physiotherapists, social workers, psychiatric nurses, psychiatrists and pharmacists will offer treatment and care in teams who work together in local neighbourhoods around the needs of patients
- Fewer people who need specialised mental health services will have to be cared for a long way from their home, families and friends
- Patients will only have to share their medical history, allergies and medication details once, regardless of whether they are in a hospital accident and emergency department or a GP surgery, and they will be able to access their medical record online
- For patients with diabetes, heart or breathing problems, technology will be able to monitor things, such as blood pressure, remotely, alerting the doctor to any problems
- As taxpayers, people can be assured that care is provided in an efficient and cost effective way.

How can I get involved and find out more?

6

Our STP is currently a draft plan under development and we will have an updated version to share by February 2017. Local public engagement events will continue and will be promoted via each partner organisation's website and other communication channels.

Please share your views at these events and if you have any questions or comments, please email:

Oxfordshire queries: cscsu.media-team@nhs.net
Berkshire West queries: ppiteam.berkshirewest@nhs.net
Buckinghamshire queries: ccgcomms@buckscc.gov.uk

Title of Report:	**Berkshire West Clinical Commissioning Groups (CCGs) Operational Plan**
Report to be considered by:	Health and Wellbeing Board
Date of Meeting:	30th March 2017

Purpose of Report:

The purpose of this report is to present to the Health & Wellbeing Board the Berkshire West CCGs Operational Plan 2017/19

Recommended Action:

To note the report

Reason for decision to be taken:

The Berkshire West CCG Operational Plan 2017-2019 reflects the priorities for 2017/19 in line with NHS guidance and NHS constitutional requirements.

Other options considered:

none

Key background documentation:

NHS Operational Planning and contracting Guidance 2017-19, September 2016, NHS England & NHS improvement.

Contact Officer Details	
Name:	Cathy Winfield
Job Title:	Accountable Officer, Berkshire West CCGs
Tel. No.:	0118 982 2732
E-mail Address:	

Implications

Policy:

Financial:

Personnel:

Legal/Procurement:

Property:

Risk Management:

Is this item relevant to equality? Please tick relevant boxes	**Yes**	**No**
Does the policy affect service users, employees or the wider community and:		
• Is it likely to affect people with particular protected characteristics differently?	☐	☐
• Is it a major policy, significantly affecting how functions are delivered?	☐	☐
• Will the policy have a significant impact on how other organisations operate in terms of equality?	☐	☐
• Does the policy relate to functions that engagement has identified as being important to people with particular protected characteristics?	☐	☐
• Does the policy relate to an area with known inequalities?	☐	☐
Outcome (Where one or more 'Yes' boxes are ticked, the item is relevant to equality)		
Relevant to equality - Complete an EIA available at www.westberks.gov.uk/eia		☐
Not relevant to equality		x

Executive Summary

1.1 The purpose of this report is to present to the Health & Wellbeing board the Berkshire West CCGs Operational Plan 2017/19.

1.2 NHS Planning Guidance: NHS England stipulates "nine must do" priorities. The Operational Plan must outline the CCG plans against these specified criteria. The nine must do's include:

- STP alignment;
- The plans must be delivered within the available allocated financial resources;
- Plans must demonstrate implementation of the General practice Forward View;
- Delivery of Urgent & Emergency care targets and priorities;
- Delivery of referral to treatment times in elective care;
- Implementation of the cancer taskforce report and deliver key standards;
- Delivery of transforming care plans and improved access to healthcare for people with learning disabilities;
- Improved quality of care.

1.3 These priorities do not encompass the full breadth of CCG responsibilities. In addition to the above NHS England also sets out specific areas where improvement is needed by 2020. This includes seven day services, patient experience, cancer, finance, Obesity & Diabetes, Dementia, A & E and ambulance targets, new models of care in general practice, health & Social care Integration, mental health, learning disabilities and autism, research, technology and health at work.

1.4 Timelines: The Berkshire West CCGs Final Operational Plans were submitted to NHS England on 23rd December 2016 and have been approved by the four CCG Governing Bodies. Initial feedback from NHS England has been positive.

1.5 All contracts with main providers (Royal Berkshires Hospital, Berkshire healthcare trust and South Central Ambulance Service) were required to be and have been signed by 23rd December 2016.

1.6 A "Plan on a Page" document has been produced by the CCGs to help illustrate and summarise the key elements of the plan on a single page. Specific CCG priorities are highlighted on the reverse page of the "plan on a page".

1.7 As in previous years the Quality Premium scheme has been offered to CCGs. This now becomes a two year scheme. Newbury & District & North & West Reading CCGs have been required to choose one Quality premium target each.

Newbury & District CCG Quality Premium

Increase the percentage of patients newly diagnosed with diabetes, on the register, in the preceding 1 April to 31 March who have a record of being referred to a structured education programme within 9 months after entry on to the diabetes register. The new Clinical Commissioning Group Improvement and Assessment Framework (CCGIAF) showed that the CCG was an outlier on this indicator, so the new target has been set at 15% which is above the national target.

North and West Reading CCG Quality Premium

Increased number of Chronic Kidney Disease (CKD) patients treated with an ACE-1 or ARB medication – When comparing North & West Reading CCG to the best 5 CCGs amongst a peer group of 10 CCGs in the latest RightCare pack there is an opportunity to improve quality of care of patients on CKD registers by increasing the number treated with an ACE-1 or ARB. The CCG has set a target to increase the number of CKD patients treated with an ACE-1 or ARB by 10%, 142 patients to 157.

Appendices

Appendix A - Berkshire West Clinical Commissioning Groups Operational Plan 2017-19
Appendix B – CCGs Operational Plan on a Page 2017-19

Consultees

Operational Plan 2017/18 – 2018/19

Wokingham, Newbury and District, South Reading and North and West Reading Clinical Commissioning Group

Table of Contents

1. Berkshire West Strategic Priorities

This document sets out the Berkshire West CCGs' ("Berkshire West") Operational Plan for 2017/18 and 2018/19. The plan forms part of the Berkshire (West), Oxfordshire and Buckinghamshire ("BOB") Sustainability and Transformation Plan (STP), and builds on the Berkshire West CCGs' strong track record of financial and non-financial performance. The year ahead, however, reflects an increased set of challenges which include delivering higher levels of efficiency savings than ever before whilst also implementing a new model of care through the Accountable Care System (ACS).

The Berkshire West CCGs are collectively recognised as high-performing and benchmark well nationally on a number of key performance measures, including non-elective admission rates and prescribing. For the last two full years, Berkshire West CCGs have been in the top 4% of CCGs for non-elective admission rates. We are also recognised across Thames Valley and nationally for leading the development of innovative approaches to improving clinical care and patient experience e.g. Diabetes Care, Stroke care, and Improving Access to Psychological Therapy services.

Nevertheless, in line with other health and care systems we are facing increasing operational and financial challenges. Both elective and non-elective activity has increased significantly in recent months with significant spikes in emergency admissions.

By 2020/21, our vision is that enhanced primary, community and social care services in Berkshire West will have a developed service model which prevents ill-health within our local populations and supports people with much more complex needs to receive the care they need in their community. People will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care. Care providers will share information, and use this to co-ordinate care in a way that is person centred, and reduces duplication and hand-offs between agencies.

This vision is underpinned by the principle that people will only be admitted into hospital, nursing or residential homes when the services they require cannot be delivered elsewhere. All the services that respond to people with an urgent need for care will operate together as a single system, ensuring that people with urgent but not life-threatening conditions will receive responsive and effective care outside hospital.

This plan has set out how the Berkshire West CCGs will deliver the NHS Five Year Forward View, working as part of the BOB STP and driving the establishment of the Berkshire West Accountable Care System. The CCGs will continue to build on strong partnership working with the three local authorities in Berkshire West to deliver the BW10 programme and maximise the impact of the Better Care Fund investment.

2. Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability & Transformation Plan (STP)

Clinical Commissioning Groups (CCGs) and providers operating in Berkshire West are members of the Berkshire (West), Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Plan (STP). This is a large STP with three distinct local health economies that are effectively driving place based commissioning to deliver the Five Year Forward View. The local health economies provide the best mechanism to transform primary

care, redesign the interface with local hospitals and drive integration with social care. Much of the delivery of the Five Year Forward View will take place at local health economy level with the STP ensuring the rapid adoption of innovation across BOB. Nevertheless each of the member organisations recognises the opportunities of working together with partners at this larger scale and will be progressing initiatives to improve quality and realise financial benefits for the wider system.

Across our STP we have a proven track record of implementing innovation and excellence in clinical practice to deliver high quality patient care. This has led to us being a highly cost effective system, which we will build on as part of this plan.

2.1 BOB STP wide programmes

For each of the proposed programmes where working at the STP scale adds value, we have developed Project Charters, with clear leadership, milestones and descriptions of benefits. These are reflected in each of the chapters of this plan. Through its ACS improvement schemes and local initiatives Berkshire West CCGs will contribute fully to the delivery of these STP wide programmes. Our ambition is to co-design with patients and clinicians and implement a new model of care to address the challenges facing our health and social care system.

Our proposals focus on the following priority areas:

BOB programme	Objectives
Prevention	• To reduce levels of adult and childhood obesity • To increase levels of physical inactivity • To reduce sedentary lifestyles
Urgent Care	• Provide an accessible and consistently high quality urgent and emergency care telephone and online advice service that promotes self-care and direct access to community based services via a single call.
Acute Services – Clinical variation	• Reduction of unwarranted variation in access to clinical care and delivery of clinical outcomes.
Acute Services - Maternity	• To ensure capacity and capability of maternity services within the Thames Valley is sufficient to respond to demand over the next 10 years.
Acute Services - Paediatrics	• To reduce unwarranted paediatric admissions within the BOB region as identified by the AHSN report. • To achieve clinical and financial sustainability for all paediatric sub-specialities across the Oxford and Southampton Children's clinical network.
Acute Services - Procurement	• Trusts work collaboratively to share procurement data and resources to improve efficiency, value and deliver cost savings.
Specialised Commissioning	• Lead, facilitate and drive integration and cross health-system redesign for specialist commissioning across STPs.
Mental Health	• Create a system for mental healthcare designed to consistently secure the best outcomes for service users and carers, building on innovation across BOB.
Workforce	• Development of a recruitment strategy • Create an education framework for the personal and professional development of health and social care support workers.

	• For Trusts within the BOB geography to achieve quality and financial improvements through the more effective utilisation and deployment of the regions healthcare workforce.
Digital Interoperability	• Delivering integrated health and care records • Empowering patient well-being and self-care through the design of personal health records

3. Local Health Economy – Accountable Care system

3.1 Delivery of the Berkshire West New Model of Care - Accountable Care System

As part of delivery of the Five Year Forward View in Berkshire West, the four CCGs which comprise 'Berkshire West'[1] are collaborating with the two local NHS providers (Royal Berkshire Hospital Foundation Trust and Berkshire Healthcare Foundation Trust) to establish a new way of working together known as an 'Accountable Care System' (ACS). New governance arrangements have been put in place led by an independent Chair and the system has applied to operate a system level financial control total as a sub division of the STP. All parties are committed to developing new payment mechanisms to underpin the transformational change required.

The Berkshire West ACS is a complete transformation of how the NHS organisations within Berkshire West will work and transact with each other. By moving away from a system of contractual transactions and closer to an allocative distribution of monies coming into the local health economy, the ACS seeks to move to a system whereby resources are allocated to the efficient delivery of pathways at cost rather than price.

The ACS represents an opportunity to fundamentally change how these organisations formally contract with each other in order to maximise the value for money available from the financial resources which are allocated to the local health economy each year, as well as improve patient experience. We are looking to the system regulators to keep pace with our ambition and provide the necessary support for this transformational approach.

3.2 Case for Change

As a local health system we are facing a number of significant operational, clinical and financial challenges including: providers coming under increasing financial, performance and quality pressures, demand management programmes with variable levels of success, workforce issues in recruitment across health and social care, and commissioners facing significant affordability pressures given the current configuration of services.

There are a number of barriers in the current operating environment that inhibit our ability to address these challenges. These are primarily the contracting and payment mechanisms and the different regulatory regimes under which each organisation operates. Other barriers

[1] NHS Wokingham CCG, NHS South Reading CCG, NHS North & West Reading CCG, NHS Newbury & District CCG

include the lack of a coherent approach to technology, workforce and patient engagement and empowerment.

The range of payment regimes across different providers has resulted in misaligned incentives that are preventing rapid transformation and the incentives for commissioners and providers to work collectively towards system wide sustainability. This system is determined that our current high standards will not fall and changing the existing tariff-based approach is fundamental to our progress. Our finances need to flow around the system in a way that appropriately pays providers and helps all organisations achieve long term financial balance by unlocking efficiencies in different parts of the system.

4. Integration – Berkshire West 10

The Berkshire West system has been working together as the Berkshire West 10 (BW10) comprising 4 CCGs, 3 local authorities, Royal Berkshire NHS Foundation Trust (RBFT), Berkshire Healthcare Foundation Trust (BHFT) and South Central Ambulance Trust (SCAS) since 2013 within a shared governance structure.

The Berkshire West 10 Integration Programme is an ambitious transformation programme involving fourteen projects / programmes across these ten organisations. These operate both at locality level and Berkshire West wide to deliver the intended benefits. The collective objective is focused on improving outcomes for users and patients, and achieving long term financial sustainability.

Overseen by an Integration Board and with project implementation supported by a joint Delivery Group, the BW10 focuses specifically on improvements for:

- Frail Elderly population
- Mental Health care
- Children's services

Much of our Better Care Fund investment is managed through this integration structure and as per national guidance has a focus on:

- Avoiding unnecessary non-elective admissions (NEA)
- Reducing delayed transfers of care (DTOC)

A summary of the BW10 projects is included below, mapped to the anticipated benefits of the overall programme of work.

BENEFITS – PROJECT SPECIFIC - alignment to BCF measures or national conditions

#	Project		Reduction in DTOC	Avoiding unnecessary NEA	Effective enablement	Avoiding unnecessary admissions to care homes	Improved experience	Better use of Resources / Cost reduction	Other National Conditions
1.	Care homes	Berkshire West		X			X	X	Joint assessments
2.	Connected care	Berkshire West		||			||	||	Data sharing
3.	Frail elderly pathway	Berkshire West	X	X		X		X	
4.	Getting home (Home First)	Berkshire West							
5.	Integrated carers commissioning	Berkshire West	X	X	X		X	X	
6.	Integrated H&S hub	Berkshire West					X	X	Support for carers
7.	Workforce	Berkshire West	||	||			||	||	7 day working
8.	Community reablement team	Reading	X	X	X	X	X		Maintaining ASC
9.	Discharge to assess	Reading	X	X	X	X		X	Maintaining ASC
10.	Joint care provider	West Berkshire	X		X		X	X	7 day working
11.	CHAS	Wokingham	X	X		X		X	
12.	Integrated short term H&S team (WISH)	Wokingham		X			X	X	
13.	Night responder	Wokingham	X	X		X			
14.	Step up / Step down	Wokingham	X	X		X			

KEY: X = supporting Berkshire West targets X = supporting Locality targets only || = enabling benefit Berkshire West wide

Page 4 of 4

5. Financial sustainability

The Berkshire West CCGs remain as some of the lowest funded commissioners in England on an allocation per person measure (£1,064 compared to a national average of £1,239), and remain underfunded when compared to their target allocations by approximately £20 a person (i.e. £10m in total). The equivalent allocation per head of a Berkshire West CCG (if it existed) would be £1,074 per person, one of the lowest in the South of England area.

Allocation growth in 2017/18 and 2018/19 averages at 2.2% and 2.1% respectively for the Berkshire West CCGs, with recurrent allocations totalling £641m and £655m in the two years. It is expected that the cost of providing the current pattern of services to our population will exceed this allocative growth during this period.

The key financial targets for the BW CCGs in 2017/19:

- Achievement of in year I&E breakeven in both years:
- Retention of 1% surplus brought forward from prior year;
- Achievement of agreed QIPP plan;
- Commitment of only 99% of resource recurrently in 2017-2018, and for half this budget to remain uncommitted at the planning stage.
- Contingency of 0.5% set aside.
- Commitment to an increase in funding for mental health in line with our percentage increase in allocation for the two years.
- Manage within our running cost allocation
- Payment to suppliers in line with the Better Payment Practice Code;

- Management within agreed cash limit; and
- Demonstrating value for money.

The four Berkshire West CCGs plan to comply with each of these requirements, recognising that this is a high risk plan and have begun an internal financial turnaround process. The size and scale of the financial challenge is greater than in previous years and may yet increase. Added to this, previous financial positions have been achieved with the aid of reserves. In 2017/18 this flexibility will no longer be available.

5.1 Alignment with activity and growth assumptions

All trust contracts will as a starting point use estimated 2016/17 outturn as the basis for 2017/19 contract negotiations.

In 2017-18 and 18-19, activity growth will be agreed with each provider based on local circumstances. Any activity savings derived from implementation of QIPP schemes will be adjusted in contracts once the detail has been agreed with the providers concerned.

5.2 QIPP and Efficiency

It is recognised that the delivery of QIPP plans is a necessary lever to ensure real change to safeguard future financial stability and it is our intention to establish realistic and achievable levels of QIPP and efficiencies within the system. The QIPP gap has been identified for the CCGs for 2017/18, and amounts to £23m in total (with £15m currently estimated for 2018-19). This year additional ACS schemes, that will deliver system efficiencies, will also help contribute towards this gap. See Appendix 2 for ACS schemes PIDS.

5.3 Parity of Esteem

Planning guidance set out the requirement for CCGs to invest further in mental health services to ensure parity of esteem between mental and physical health services. Berkshire West CCGs have committed to investing in line with their increased allocation. Any increased investment may be utilised in a number of organisations within the health economy including Berkshire Healthcare FT, Royal Berkshire Hospital FT, CCGs, the voluntary sector and Primary Care.

5.4 Moderating demand

Despite a number of initiatives being put in place during 2016/17 to reduce non-elective activity the system continues to see growth in non-elective activity in excess of plan, although this is below the national average in a population with high and rising numbers of the elderly. A number of schemes are being developed to mitigate this pressure in the coming two years.

5.5 Improving health

The CCGs recognise the importance of prevention and health promotion in reducing the ultimate demand for healthcare. Effective, evidence-based prevention, addressing the lives

people live, the services they access and the wider context in which they live will require co-ordinated action and the CCGs are working closely with Local Authority colleagues to ensure these services are delivered effectively across Berkshire West.

This collaborative approach is exemplified by the Prevention Working Group, part of the Berkshire West 10 Integration Programme, which will enable identification and sharing to develop best practice across the region and will support the development of health promoting organisations.

5.6 Accountable Care System

The current profile of service provision in Berkshire West is not sustainable and this position will worsen unless action is taken to address the challenges set out above, promoting primary and preventative care. In 2017/18, our system is forecasting an overall financial gap to be bridged of approx. £52m:

	2017/18 savings required (£m)
Royal Berkshire NHS FT	(23)
Berkshire Healthcare NHS FT	(6)
Berkshire West CCGs	(23)
Total	**(52)**

5.7 Primary Care

Berkshire West CCGs recognise that primary care is a key part of the system and faces significant challenge in terms of demand and workforce pressures. Ahead of the GP Forward View the CCGs have already invested £5m in primary care in each of the last two years to enhance access and maximise the impact of care planning and ensure we provide proactive support to care homes. In 2016-17 the CCGs took on fully-delegated responsibility for commissioning primary medical services bringing a strategic capability to the commissioning of primary care and supporting its integration with the wider health and social care system.

5.8 Better Care Fund (BCF)

In 16/17 the Berkshire West CCGs Minimum Contribution to the BCF was £25.7m, representing just under 84% of the total BCF funding of £30.6m. Although we do not yet have the NHS England Allocations for 17/18 and 18/19, planning is proceeding on the basis of a broadly similar level of funding to that in the current year.

For 2017-19 the intention is to build on the foundations of the integration programmes which have been successful so far, while continuing to critically evaluate all schemes and where necessary redirect investment towards reconfigured or new projects. The plans will be subject to sign off by Health and Well Being Boards by March 2017

6. Supporting Self Care and prevention

The Berkshire West CCGs measure well against national life expectancy, Newbury and Wokingham areas are both in the top decile of affluence and exceed national life expectancy, though Reading with lower affluence has lower life expectancy with men being below the national average (78.5 years). Similarly the potential years of life lost (PYLL) due to amenable causes are lower in Wokingham and West Berkshire, though similar to the national average in Reading.

The STP prevention programme and the linked local prevention programme reflect priorities that tackle the causes of inequalities in our communities. The Buckinghamshire, Oxfordshire, and Berkshire populations benchmark well against the England average for public health outcomes. However within all our areas there are pockets of our residents where outcomes are not good, and so the direction of the programmes is to address the factors that drive these inequalities, with a slight modification to include diabetes (which is linked significantly to being overweight) and physical inactivity (due to the increasing recent evidence on the separate impact of physical inactivity on health).

Prevention programmes can be delivered in a variety of settings and at different population levels. At an STP level two key enablers have been identified to drive programmes to change lifestyle behaviours:

- engaging with health and care staff to maximise the "teaching moment " of care delivery to nudge lifestyle choices "Making Every Contact Count" and
- industrialising our use of digital approaches, linking with the Connected Care programme, to improve knowledge on lifestyles, signposting to services and supporting / coaching lifestyle changes

These benefit from a STP approach and will drive delivery in two key lifestyle areas: reducing levels of obesity in adults and children and improving levels of physical activity. In addition the staff programme "Making every Contact Count" will also drive stretch improvement in NHS employee health, building on the national CQUIN initiatives, improving staff indicators and will link with an Academic Health Science Network wide programme to engage with other major employers to maximise employee health.

Locally 'Beat the Street' is a well-established programme of increasing activity and will continue in to 2017/19. Between 15th April and 27th May 2016, 6,876 people from Reading registered online to take part. Many others, including school children, took part but did not register individually. At the end of Beat the Street, 3,216 people who provided an email address and agreed to be followed up were invited to provide feedback. In total, 570 people did so (18%). The proportion of adults reportedly meeting this target increased from 36% to 53% which is statistically significant. Positive trends were also apparent for children, though the numbers were too small to draw conclusions. Importantly the proportion of people who were active on only 0 or 1 day per week reduced from 15% to 5% by the end of Beat the Street ($p<0.05$) and people with long-term conditions were just as likely to report benefits as everyone else.

6.1 Long term conditions and self-care

Our work on long term conditions (LTC) will significantly contribute to the ambition of the Five Year Forward View and our local strategic vision for 2019 which sets out an ambition for enhanced primary, community and social care services in Berkshire West to have a service model which prevents ill-health within our local populations and supports patients with much more complex needs to receive the care they need in their community.

Our vision is underpinned by the principle that patients will only be admitted into hospital when the services they require cannot be delivered elsewhere, and that when acute care is needed they will be treated in centres equipped with the appropriate facilities and clinical expertise. People with serious and life-threatening conditions will continue to be treated in acute centres that maximise their chances of survival and a good recovery.

In transforming our approach, it is recognised that there is a fundamental shift from more traditional reactive and unplanned approaches to one which is truly patient centred, proactive and anticipatory, where possible enables patients and carers to access services at or as close to home as possible and aligns specialist, primary and community care in one coherent package, and where required along a continuum of care which meets palliative and end of life care needs. Service users will be supported to take more responsibility for their health and wellbeing and to make decisions about their own care.

The Berkshire West LTC Programme aims to identify effective and sustainable approaches to underpin the prevention of an avoidable increase in health need that may lead to a loss of independence and an increase in demand on services. Using profiling and risk stratification tools we will be able stratify populations to ensure resources are targeted most effectively and efficiently. Demand for services is predicted to continue to rise with a growing older population and people living with more complex long term conditions. We will expand our focus beyond the top 2% of the population to the top 10% who may not necessarily be high users of services now but are at risk of becoming so without early intervention.

We will move towards a model which reduces fragmentation, and is underpinned by care and support planning. This has been successfully embedded as an approach for diabetes, based on the Year of Care approach and has been partially adopted as an approach for COPD. This provides a strong foundation on which to build our new model of support to people with multiple Long Term Conditions to include respiratory disease, cardio-vascular disease, mental health and dementia. This would move from a system focused on a single condition towards a more patient centred, holistic approach improving health and wellbeing, streamlining and improving quality of care including earlier intervention and approaches which reduce the impact on specialist resource. There is real opportunity to progress this at scale.

Through our BCF initiatives, we will continue to work collaboratively across health and social care and the voluntary sector to provide quality care for patients; minimising the risk of an individual's health deteriorating and requiring increased service intervention, and maximising opportunities for patient self-management.

6.1.1 End of Life Care

Meeting the palliative and end of life (EOL) care needs of patients (and their carers) along a continuum of care is critical to our overall vision and approach to integrated long term conditions management. This enables us to drive forward patient centred, holistic end of life care regardless of specific conditions, with services wrapped round the patient and where possible provided at or closer to home. It also focuses on a planned and proactive approach, minimising reactive and crisis response which often leads to hospital admission as the only option.

Locally, benchmarking data indicates that we are deemed to have a higher percentage of deaths in hospital at end of life. However, we know that this is higher in Newbury where there are a number of hospice style beds within the community which contributes to the overall reporting. The average however across Berkshire West is better than the national.

There are a number of initiatives in place across the area which supports proactive approaches to the management of end of life care, with the aim of enabling patients/individuals to die in their preferred place of residence. This is highly reliant on our whole system approach to reduce the impact of urgent/crisis response and ensuring that palliative and end of life care needs are considered integral to all LTC work.

The EOL Steering Group meets quarterly, with representation from all key stakeholders and reports into Long Term Conditions (LTC) Programme Board. This ensures that all the LTC work programmes align with ambitions for EOL e.g. Heart Failure/COPD/Dementia as key examples and aligns to other programme areas e.g. urgent care and cancer. This was set up is in recognition that End of Life is a crosscutting theme across a wide range of disease areas.

The Steering Group has been a key driver in progressing commissioning of a new 24 hour, 7 days a week Palliative care co-ordination and support service called “PallCall.” The service, with a single point of contact for patients, families and healthcare professionals, is available to anyone in their last 12 months of life with a Berkshire West GP, or to anyone who is providing support to those people. The service is designed to support End of Life patients to die in their preferred place and to prevent avoidable, unwanted admissions for that patient group. PallCall launched in mid-October 2016 and has in its first six weeks, dealt with 100 calls from patients, families, GPs, care homes, district and community nurses, and the ambulance service. They have prevented 19 admissions and supported 6 patients to die in their preferred place. The service is still developing and we will build on these early successes to deliver in home assessment directly in 2017/18, and to ensure GPs caring for palliative patients have considered anticipatory medication.

In addition Berkshire West uses Adastra to deliver the Electronic Palliative Care and Co-ordination System (EPaCCS) thereby contributing to the co-ordination of patient care through access to patient relevant information, with all GPs having access alongside A&E (a terminal in A&E) and SCAS. Additionally A&E and SCAS have GP Bypass numbers to reduce the need for conveyance and/or admission as the only option and ensures the needs and wishes of patients are addressed. There is additionally access to the hospital based palliative care team and access to the 24/7 PallCall service.

There are a number of additional schemes which support and enable patients to remain in their preferred place of residence (including care homes) and where possible reduce the need for admission to hospital and/or A&E attendance. These include the provision of inpatient beds and the West Berks Community Hospital Rainbow Rooms. Patients also have access through our community and acute services in the form of:

- The Rapid Response Team for patients in own homes (and care homes)
- Hospital based palliative care team

The Anticipatory Care Enhanced Service (CES) in addition supports both the implementation of care planning and Do Not Attempt Cardiac Pulmonary resuscitation (DNACPR) discussions for patients approaching end of life.

We will also further build upon the EOL CQUIN put into place in 16/17, with the community providers which has improved the recognition of those patients who are entering their last year of life and are on the caseload of a community service (e.g. District Nurses, Community Nurses, Community Matrons, & Inpatients). The CQUIN supports organisational development and delivery of an action plan to improve the ability of appropriate staff to identify patients who might be entering the last year of live, flag those patients on appropriate clinical systems and work effectively with GPs and the palliative care hub to support co-ordinated working for that patient.

Increasing access to healthcare education and shared learning has led to the development of a rolling programme of education across all CCGs. Practices can benefit from the local Palliative Care Consultant for case based discussion teaching. This has included managing difficult conversations and/advanced care planning, ultimately supporting the overall approach to improving patient care and outcomes.

There is also a Palliative Care Community Enhanced Service (CES) which supports one GP per Practice per year to attend a relevant EOL learning event and to subsequently evidence that this learning has been disseminated through the Practice team.

6.2 Diabetes

Across Berkshire West CCGs, we recognise Diabetes as a significant issue with the prevalence and number of people at risk of developing Diabetes being very high in some areas (such as the south of Reading).

The House of Care and Care & Support Planning have been central to the Diabetes service re-design over recent years. Within Berkshire West we have strong clinical leadership and an integrated approach to the management of diabetes, which has been widely recognised and acclaimed nationally.

Our vision is to identify people at risk of developing Diabetes early and refer them to risk-reduction services. We will also support people with diabetes in Berkshire West, to live healthier lives by improving outcomes and reducing complications, and to do that efficiently. We aim to do this through informed, engaged patients, informed motivated Health Care

Professionals, collaboration between stakeholders and supported by the use of informatics and technology.

Across Berkshire West, we have commissioned a community enhanced service (CES) for pre-Diabetes since 2013, and have committed future funding for a three year period through to 2019. This CES has successfully identified Diabetics and Pre Diabetics as well as promoting lifestyle interventions for Diabetes prevention. This has provided us with a sound base as early adopters within the national Diabetes prevention programme, successfully participating in the first-wave as a pilot site across the whole of Berkshire (all 7 CCGs and 6 LAs). This programme is locally led by Public Health working closely with the CCGs and complements the local CES scheme. More than 30 GP Practices across Berkshire have invited 576 patients with pre-diabetes to the NHS NDPP programme. With 147 patients (26% uptake) so far being enrolled, the number of invitations and referrals each month continues to rise by the rate of additional GP surgeries being enrolled onto the programme. Across Berkshire we envisage that we will refer at least 2,300 people with pre-diabetes in first year for risk reduction, building on the early successes in the CES.

In South Reading CCG where there are higher levels of diabetes the GP practices are participating in a Prescribing Quality Scheme, which includes specific diabetes related prescribing targets aimed at optimising prescribing of medications to improve outcomes for diabetic patients. The development of prescribing formularies by the Medicines Optimisation Team supports prescribers in ensuring that the most cost effective treatments are used in line with NICE.

We will continue to commission an innovative interactive database technology "**Eclipse"**, to which all our practices have access. ECLIPSE is a software tool originally procured by Berkshire West CCG's to help support improvement in diabetes care. Use of the software has had a significant impact in improved diabetes care and now increasingly supports identification of risk in a range of other Long Term Conditions. Berkshire West have subscribed to the advanced "LIVE" version which includes true Risk Stratification, Safety Alerts, Centralised Project Management, Integrated Care and Automated Patient Care Plans. Weekly extracts allow practices to identify at-risk patients and automatically generate safety reports. In addition Berkshire West has developed an extremely effective Community Diabetes Service, led by a Community Diabetes Consultant and support network of Diabetes Specialist Nurses. This team uses Eclipses' virtual capability to identify practices needing support in the delivery of high quality diabetes care to its patients in a highly effective and cost efficient way. Eclipse has the capability of being utilised for the management of other long term conditions. We have put into place a system of remote monitoring of blood glucose in diabetic pregnancy.

South Reading CCG was one of eight CCGs in England participating in a CQC Diabetes thematic review which demonstrates and shares best practice examples across the country. South Reading has been cited in this report as demonstrating a number of areas of good practice. One such area is our comprehensive range of health care professional and patient education programmes for type 1 and Type 2 Diabetes. This is a key element of the House of Care model. Our commissioned XPERT course (type 2 Diabetes education) delivered by Berkshire Health Care Trust, recently received two national awards. Type 1 Diabetics have access to our local course "CHOICE", commissioned in 2016, which now offers greater capacity, more sustainability, greater cost-effectiveness, and for patients much more

convenience. In addition, type 1 diabetics have access to a short three-hour carbohydrate awareness course, combined with instruction on basal dose optimisation and bolus/correction dose instruction. 700 of our type 1 diabetics have been able to access this course. However we know from Eclipse, that as of October 2016, we have 2144 type 1 diabetics and 18,403 type 2, an increase on last year of 17% and 9.8% respectively. To meet this rising demand during 17/19 we will be addressing this challenge of reaching even more diabetics, and we are undertaking a review of a range of education offers and in particular options to include using online education with better use of technology. By early 2017, we will have identified and costed a range of options to better meet the future demand.

Other local initiatives to directly support and reduce the numbers of patients with very badly controlled diabetes include the insulin optimisation programme. This was set up in 2015, to provide a more focussed opportunity to work with individuals with Type 2 Diabetes who are not optimally controlled. The overall objective is to reduce individuals HbA1c levels and therefore improving their longer term health outcomes. This service has been reviewed in 2016 and we have been able to demonstrate 53% of those who attended had achieved a 10mmol/mm reduction in their HbA1c levels and of these 55% achieved changes of 20mmol/mm or more. A 10mmol/mol reduction in HbA1c levels tallies to a 17% reduction in events of non-fatal myocardial infarction and a 15% reduction in events of coronary heart disease. Throughout 17/18 and beyond we will continue to build on this success and implement further actions identified which will see improved uptake of support within the programme as well as improved data capture around insulin type associated with the courses.

Using a variety of data sources and analysis combined with our self-assessment against NICE criteria of service delivery, we have identified other inequalities and variation in Diabetes care, resulting in committed funding for 17/18 to offer a new service for the care of highly complex diabetic patients. This cohort of patients is known to have frequent associated emergency admissions. This builds on the success seen in the “virtual diabetes” clinics and will see the implementation of a community based service for this often dis-engaged patient cohort, aiming to reduce non-elective admissions and readmissions through improved Diabetic control.

These initiatives, combined with good quality education for our health care professionals, helps support and address the findings from the National Diabetic audit (100% participation rate), the recent 2016/17 CCG Improvement and Assessment Framework also tells us that more work is needed to improve coding of those attending education and to improve outcomes for diabetics locally, preventing them from developing complications and progressing to renal replacement therapy.

6.3 Obesity and Diabetes

The provision of comprehensive weight management services to our population is an important priority to help address and prevent people developing other illnesses, including Diabetes, which in turn further increases the health burden in our local area.

Weight management services are categorised into 4 tiers as outlined below. Tiers 1 and 2 are commissioned for people in Berkshire West by our three local authorities. Tier 4 (pre

surgical assessment and Bariatric surgery) is commissioned through specialised commissioning but will move to CCG responsibility on 1st April 2017.

Currently there is no provision of Tier 3 weight management service for the Berkshire West CCGs and prior to the transfer in April 2017; we plan to establish a Tier 3 services offer as the missing part of the weight management pathway. This will provide a more specialist intervention delivered by a multidisciplinary team with an aim to support and reduce the numbers of patients moving to Tier 4 (bariatric surgery) and reducing the development of other illnesses.

We have already begun discussions with our partner CCGs within the STP, BOB footprint with the aim of commissioning a service that can be provided across the geography that is consistent and supports the needs of our local populations. The aim is to provide a Tier 3 weight management intervention service as recommended by NICE guidance (CG 189). Work has taken place in 2016/17 to estimate demand for a new service and also anticipated investment costs. This business case will form a sound basis to move forward into 2017 and beyond with a comprehensive offer to our populations.

The provision of Tier 3 in Berkshire West of a Weight Management intervention service will lead to a step change within the NHS in preventing ill health and supporting people to live healthier lives, specifically addressing obesity and reducing the risk of diabetes.

7. Primary care

An effective and sustainable primary care sector will be a key element of our Accountable Care System. As fully-delegated primary care commissioners we are working with our member practices to deliver a strategic programme for primary care which will meet the following key objectives for primary care set out in the *Berkshire West Primary Care Strategy:*

- Interfacing in new ways with specialisms historically provided in secondary care to manage increasingly complex chronic disease in a community setting.
- Managing the health of a population by working in partnership with others to prevent ill-health. Acting as accountable clinicians for the Over 75s and other high risk patients and co-ordinating an increasingly complex team of people working in primary, community and social care to support patients at home.
- Using new approaches and technologies to improve access and patient experience, ensuring that the needs of patients requiring urgent primary care are met appropriately and appointments are available in the evenings and at weekends.
- Making effective referrals to other services when patients will most benefit.

Delivery of these objectives is predicated on ensuring the sustainability of the primary care sector. As CCGs we have already invested £5m in primary care over the last three years and have established work streams relating to new workforce models, estates, access and IM&T. We have procured three new APMS contracts aligned to local need and have supported practice mergers and joint working, resulting in the emergence of a new GP provider organisation in South Reading CCG and shared approaches to workforce in the other CCG areas. We are currently piloting clinical pharmacist roles in two of the CCGs and have commissioned training for administrative staff to enable them to assist GPs in co-

ordinating care as well as working with the University of Reading to launch a training programme for Physicians' Associates for which many of our practices now provide placements. We have also established robust processes for undertaking the functions delegated to us by NHSE, including a quality improvement programme based around a Quality Dashboard which combines local and national data to give a 'rich picture' of local primary care provision, enabling us to work to improve the quality of care provided and address any areas of poor performance.

Under the ACS model we will look to primary care providers to offer proactive care to their registered population; supporting patients with long-term conditions in the community, working to prevent ill-health and co-ordinating robust care plans for patients most at-risk of admission. We have already invested significantly in care planning in primary care and are working to further refine our model, including enhancing links with care homes. However in order to ensure there is sufficient capacity for primary care to undertake this role, we believe that same-day demand needs to be managed differently and we are working with our practices to explore the potential for collaborative working to stream demand through Primary Care Access Hubs and other joint arrangements. These collaborative approaches will also offer opportunities to commission extended hours differently. We intend to build upon the Enhanced Access CES we have already commissioned to move towards delivering our trajectory to meet the requirement for all patients to have access to routine and booked appointments each early morning and evening and on both Saturdays and Sundays. Hubs would also align with the broader urgent care system including the re-procured NHS 111 service and it is also our intention to review the role of the Reading Walk-in Centre within this model of provision.

As this 'ask' of primary care becomes further defined, we will continue to work closely with provider leads to consider the models of care which will best deliver it for our population, recognising that the provider landscape is likely to vary somewhat across the four CCGs. We have started to discuss the potential opportunities offered by the new MCP contract with providers and will step this up once more details of the contract are released. We anticipate that a combination of federations, networks and practice mergers will move us towards the future state described in our Primary Care Strategy where at-scale providers cover at least 10,000 patients and usually 30,000 or more with increased skill-mix work in an integrated way with other ACS partners to care for patients in the community wherever possible.

Our local GP Forward View implementation will set out in more detail how we intend to realise this vision for primary care (see Appendix 4). We have already identified three key enablers; capacity for practices to consider how their future business model will make them sustainable, workforce diversification and infrastructure.

With regard to practice sustainability, we are already using Vulnerable Practice and Practice Resilience funding to support practices to plan for the future, utilising the ten High Impact Changes where appropriate. We will now support practices to access the Time to Care and General Practice Improvement Leaders' programmes, working closely with those that choose to use these processes and considering how we can make funding available as set out in the planning guidance to continue to support those for which a different approach is required.

As set out above we have already established a workforce programme for primary care and will now be linking this with the various initiatives and funding streams announced in the GPFV, for instance to roll out our clinical pharmacist programme and establish the role of mental health therapists in primary care. In addition we have submitted an application to HETV to develop a Community Provider Education Network in our area which we will act as a vehicle for supporting recruitment and retention through enhanced continued professional development and for the broader diversification of the primary care workforce.

Infrastructure development is a further key enabler and our ETTF bids reflect the CCGs' local strategic priorities for premises and IM&T investment. The proposed premises developments are required to support at-scale working and respond to significant population growth in Newbury and Wokingham in particular. Similarly, investment in IM&T will provide the early interoperability that will underpin practice collaboration and will sit alongside our broader strategy to maximise the potential of technology in meeting demand and co-ordinating care. Section 14 of this document describes our Digital Roadmap and initiatives underway to open up new ways for patients to access primary care and to ensure we make best use of existing tools such as online access, e-referrals and EPS.

8. Planned Care

Our strategy for Planned Care will deliver a step change in the productivity of elective care by redesigning planned care services to improve health outcomes for patients, reducing lengths of stay in hospital and fundamentally reviewing the delivery of outpatient services. Our vision includes the use of new technologies to enable our patients to interact with services in new ways; we will explore virtual clinics and other modalities to deliver some of the functions currently provided by outpatient departments.

To date we have been working to enable patients to make informed decisions about their care and where secondary clinical interventions are necessary to have access to specialist assessment and treatment and in line with national performance standards.

We are part of phase 2 of the national Right Care Programme and we already adhere to the principles outlined in this programme and utilise the tools to scope opportunities across all CCGs in Berkshire West to highlight unwarranted variation and develop solutions working with all stakeholders to redesign services. Our Integrated Pain Assessment and Spinal Service (IPASS) is an outstanding example of applying these principles and this service won an award for Emerging Best Practice from the British Society for Rheumatology. The Right Care Approach will support and underpin all delivery programmes by focussing on reducing unwarranted variation to improve people's health and outcomes, and ensure that the right person has the right care, in the right place, at the right time offering better value to patients, the population and the taxpayer.

As part of the Accountable Care System (ACS) model we are already working closely with our acute trust provider to review end to end pathways and redesign services to implement the required step change in productivity.

Our Planned Care Programme of work for 2017/2019 includes continuing work to redesign and streamline pathways and reduce clinical variation focusing on Orthopaedics and MSK

(including patient self-referral for physiotherapy), Ophthalmology, Diagnostics, efficiencies in outpatients including exploring other modalities for follow ups (e.g. virtual clinics, telephone follow ups), access to consultant advice and guidance for GPs, patient initiated clinics and Pre-op assessments.

This programme of work will become part of our ACS clinical improvement programme. Working closely with our acute trust providers we plan to take a systematic approach to the commissioning and redesign of following services:

1. MSK
2. Ophthalmology
3. New model for delivery of Outpatient appointments:
    a. ENT
    b. Audiology
    c. Pre op assessments
    d. Other modalities for follow up

Through this work we aim to apply national best practice to reduce clinical variation and ensure appropriate referrals are made to secondary care, and redesign outpatients.

8.1 Cancer

Significant improvements in cancer wait time standards have been seen during 2016/2017 at RBFT, the main acute provider for the CCGs in Berkshire West. The Trust is forecasting to achieve the 62 days target from Q3 onwards. The CCGs are expecting that this performance will be sustained during 2017/18 and beyond and is one of the best performers in RTT in the region. The CCGs will continue to focus on working with RBFT to reduce the size of the backlog of patients waiting beyond 18 weeks yet to be treated, especially those with the longest waits beyond 40 weeks. In aligning our demand and capacity modelling we have factored in the capacity required to achieve the national performance standard, including diagnostic capacity.

The Berkshire West CCGs have jointly developed a cancer framework (see Appendix 5) with stakeholders from RBFT, Public Health, Thames Valley Strategic Cancer Network, Macmillan and Cancer Research UK to improve the outcomes for people affected by cancer in Berkshire West. Through this framework we will deliver the strategic priorities outlined in “Achieving World-Class Cancer Outcomes: A Strategy for England” over the next five years.

The framework includes a series of initiatives across the patient pathway emphasising the importance of earlier diagnosis and of living with and beyond cancer in delivering outcomes that matter to patients. We plan to reduce the mortality rate and increase survival rates through early diagnosis, appropriate interventions, delivering high quality care to improve patient experience, promote national and local awareness and provide care closer to home.

The Berkshire West Cancer Steering Group has been formed with all of the relevant stakeholders to lead the delivery of the prioritised strategic objectives and will work through the local Cancer Alliance.

Our overall ambition is to prevent people from dying prematurely by decreasing the potential years of life lost (PYLL) from cancer related causes and decreasing the under 75 mortality rate from associated cancers.

We also continue working with RBFT colleagues to understand and forward plan for the demand and capacity required over the coming years taking into account the impact of changes in demographics, increasing demands for diagnosis from cancer pathways, compliance with NICE Guidance on suspected cancers, GP direct access and diagnosis expected earlier in the pathway (as per the upcoming 28 day standard).

9. Urgent and emergency care

During 2017-18 and 2018-19 we will continue to work with the Berkshire West A&E Delivery Board which brings together system leaders from partner organisations to ensure delivery of:

- The NHS Constitutional Standard that 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at A&E
- The 5 national mandated actions to improve A&E Performance
- Further locally agreed priorities for the Berkshire West System arising from two "Roundtable" events held in July and September 2016

The Board will also work closely with the Thames Valley Urgent & Emergency Care Network (UECN) to further deliver the vision of the national Urgent and Emergency Care review. The TV U&ECN is focused on delivery of the 3 national strategic asks of the network:

1. Development of a roadmap for delivery of the following for 100% of the population by 2020-21:
    - All patients admitted via the urgent and emergency care pathway to have access to acute hospital services that comply with the four priority clinical standards on every day of the week
    - Access to Integrated Urgent Care, to include at a minimum Summary Care Record, clinical hub and 'bookability' for GP content; mental health crisis response in hospital; Ambulance Response Programme
    - Improved access to primary care in and out of hours
2. Carrying out further enabling activities for delivery of Keogh Review in 2017-18
3. Designate 'local' UEC services and standardise delivery e.g. Urgent Care Centres to be open 16 hours daily with x-ray and blood testing available throughout.

The Delivery Board have an agreed work plan which addresses both the 5 nationally mandated improvement actions and locally agreed priorities for the urgent & emergency care system. Berkshire West has held two Urgent Care Roundtable events in July and September 2016 which have helped to shape the strategic and operational priorities for the AEDB.

Key themes from the plan include (see Appendix 6 for full plan):

- ED streaming
- Increase in NHS 111 calls being handled by clinicians
- Delivery of the Ambulance Response programme (ARP)
- Measures to improve flow

- Improving Discharge processes/DToC performance by implementing the national Choice policy, strengthening CHC processes and the “Getting Home” project

9.1 Thames Valley Integrated Urgent Care service

Key local priorities as part of this overarching programme are the mobilisation of the Thames Valley 111 Integrated Urgent Care service from 2017/18 and a review of the contribution of Reading Walk In Centre.

The UECN is leading the Urgent Care work stream of the STP and Berkshire West CCGs are actively working to achieve the agreed deliverables, in particular Berkshire West is leading the procurement of a new Integrated Urgent Care service across Thames Valley.

Key deliverables for the workstream are:

- Regional 111 Integrated Urgent Care service, including enhanced clinical hub and enhanced Directory of Services
- Standardisation of UEC clinical pathways and designation, mapping and signposting of UEC services across the Thames Valley UEC network area
- Interoperability of UEC systems that allow the patient record to travel with the patient and be accessible to healthcare professionals across the patient pathway
- U&EC competency framework and workforce ‘passport’ arrangements across Providers
- Establishment of interface clinician roles offering portfolio employment across UEC services
- Best practice framework for 7 day access to standardised care across primary, community and secondary settings.

The Integrated Urgent Care (IUC) service, which launches in 2017/18, will offer a step change in meeting the urgent and emergency physical, mental and social care needs of patients across Thames Valley. NHS 111 will have the potential to be the single entry point to all urgent care services for the public.

The IUC service will offer improved management of patients with an increased clinical work force who can provide clinical review and early intervention for patients including vulnerable groups such as under 5s, patients at the end of life, support for self-care where clinically appropriate, and greater integration with downstream services such as community health and social care hubs. The service will provide improved transfer of patient information and access to care records.

Patients will be confident that, with one call to 111, the care that they are directed to will meet their physical, mental and social care needs in a timely and clinically safe manner. Health and Social Care professionals will be confident that the 111 Integrated Urgent Care Service has assessed and managed patients appropriately, placing them with the service that can most effectively meet their needs.

The Clinical Advice Hub is a new feature that will serve two purposes: providing enhanced clinical advice and management to patients contacting the service including generalist and specialist advice such as mental health, dentistry and pharmacy; and providing support to

clinicians (particularly ambulance staff such as paramedics and emergency technicians) via dedicated Health Care Professional (HCP) lines to ensure that no decision is made in isolation without proper clinical advice. The Hub will, in time, become the one location where a patient's physical, mental and social care needs can be co-ordinated and become, through patient's experiential learning, the choice for access to care.

9.2 Four priority standards for seven-day hospital services

As the main provider of acute services of in this area, Royal Berkshire NHS Foundation Trust are making strong progress with the implementation of the four priority standards for 7 Day Services (7DS).

As a result of this focused and targeted approach, the current position is as follows:

N	Standard	RBH Position
2	Time to first consultant review	Fully compliant
5	Access to diagnostics	Partially compliant
6	Access to Consultant-directed interventions	Fully compliant
8	On-going Review	Fully compliant

Berkshire West CCGs will continue to ensure that the provider is best placed to achieve as many of the standards (and maintain this position) as quickly as possible.

9.3 Ambulance response times

During 2015/16 and 2016/17 SCAS has been challenged in delivering the ambulance response time standards for the Thames Valley contract. All three of the national standards will not be met for the year. The CCGs have had a remedial action plan in place during 2016/17 that is forecasting recovery in the month of February 2017. This plan assumes activity levels are in line with agreed contractual levels; however it is worth noting that up to the end of August 2016, activity was 7.8% above plan which puts delivery against the plan at risk. A trajectory for 2017/18 is yet to be agreed with the provider.

When compared to other providers nationally, SCAS is one of the best performers against the national standards and was also the first ambulance service to receive a Good CQC inspection result. There is a national programme underway piloting various different response time options and the outcomes of these pilots are expected in early 2017 and this is likely to result in a change in targets within the 2017/19 contract.

9.4 Avoidable transportation to an A&E department

The IUC service will provide safe, effective and responsive integration with emergency ambulance services ensuring that ambulances can be dispatched without delay as clinically appropriate, for life-threatening 'Red' cases.

Patients that do not require an emergency response will be warm transferred to the IUC hub for review by a clinician and management in a more clinically appropriate community setting. 'Green' ambulance dispositions reached through NHS Pathways by 111 will be automatically transferred to a clinician for review and, where appropriate, patients will be supported to

access alternative services in the community that are appropriate to manage their level of need.

An improved, up-to-date Directory of Services (DoS) will also be central to the IUC service, including a comprehensive range of local health, community, third sector, mental health and social care service information that can provide support where appropriate. The DoS will also be made available to health professionals to search for local services to support their patients and make better decision making to manage a patient, where appropriate, in the community without recourse to attendance at an Emergency Department or admission due to lack of knowledge of local care.

SCAS are proactively seeking local opportunities to increase see and treat rates where clinically appropriate. See and treat hubs are being established to increase see and treat support through Specialist Paramedics. Five sites have been identified across the SCAS geography with a pilot currently running in Reading. The CCGs will work with SCAS in 2017-18 on delivery of the CQUIN "A reduction in the proportion of ambulance 999 calls that result in transportation to a type 1 or type 2 A&E departments". The CQUIN will act as a driver in the development of ambulance services as they become community-based providers of mobile urgent and emergency healthcare, fully integrated within Urgent and Emergency Care Networks. The CQUIN will incentivise SCAS to manage a greater proportion of care closer to home and reduce the rate of ambulance 999 calls that result in conveyance to A&E.

10. Mental health

The core objectives of the Five Year Forward View for Mental Health are to improve access to high quality care, provide early intervention and integrated services with the aim of reducing spend in acute settings and inpatient services. In Berkshire West across 2017/19 we will commission mental health services which will enable savings to be realised across the health and social care system by providing people with the most appropriate care in the right setting, this will align to the BOB STP mental health workstream objectives.

Working with our main provider, Berkshire Healthcare Foundation Trust (BHFT), we will lead service transformation to bring services in line with National Standards to meet the Parity of Esteem "Call to Action Framework" and we will be working with them to deliver the two new national mental health standards.

The CCGs are leading a local Mental Health Taskforce for Berkshire West and this will be the first time there has been a strategic approach to improving mental health outcomes for people of all ages in the health and social care system.

In 2016/17 we have made significant investment in mental health services to support the delivery of 'Parity of Esteem' and we will continue to drive change throughout the next two years to ensure all our mental health users and carers receive a high quality, outcome focussed service comparable with physical health care. As part of the primary care five year forward view Berkshire West have invested in primary care to provide physical health checks for those patients with a severe and enduring mental health illness in the community. In

addition BHFT are committed to increasing physical health checks for patients within the community.

10.1 Crisis Care

In relation to crisis care, we have invested in expanding our Crisis Response and Home Treatment Teams (CRHTT) that will make a critical contribution to managing the pressures on acute in-patient beds that lead to increased bed occupancy and, ultimately, to people being sent out of area. The acute care pathway that we are developing during 2017/18 will incorporate demand and capacity management and will use learning from other areas where the acute care pathway has been redesigned so as to completely eliminate Out of Area placements (OAP). By redesigning our crisis care pathway into CRHTT we will see the benefit from reduced mental health in-patient admission at Prospect Park Hospital and reduce delayed transfers of care.

The Berkshire Crisis Care Concordat describes what people experiencing a mental health crisis should be able to expect of the public services that respond to their needs and how different services can best work together. The Berkshire Concordat Action Plan has been informed by engagement with people who have needed to use crisis services and establishes key principles of good practice that local services and partnerships should use to raise standards and strengthen working arrangements.

Our local concordat focuses on the need for agencies to work together to deliver a high quality response when people with mental health problems need help; to establish joint intent and common purpose as to the roles and responsibilities of each service.
Berkshire Crisis Care Concordat is arranged around four key areas;

- Access to support before crisis point
- Urgent and emergency access to crisis care
- Quality of treatment and care when in crisis
- Recovery and staying well/preventing future crises

We are working with partners to provide better access to support people before crisis point by:

- Providing a rapid response service 24/7 to all urgent and emergency mental health crisis
- Delivering an early intervention and prevention service
- Ensuring people in crisis will be kept safe, have their needs met and be helped to achieve recovery
- All staff having the right skills and training to respond to mental health crisis appropriately
- Ensuring access to our local 24 hour helpline staffed by mental health professionals for people in crisis, their carers and GPs
- Delivery of the Crisis Resolution and Home Treatment Team, available 24/7
- Delivery of a street triage service and places of safety

Both the Crisis Response Team and the Home Treatment Team will be fully operational on a 24/7 basis from 2017/18.

The effective planning and management of mental health service pathways, including the involvement of patients and their carers in the development of Berkshire West Crisis Services, will support more people to have good mental health and those people with mental health problems will recover quickly.

10.2 Improving Access to Psychological Therapy (IAPT)

The Berkshire West IAPT service has been achieving the target of 75% of people with relevant conditions accessing talking therapies in six weeks and 95% within 18 weeks. The Berkshire West IAPT service has been recognised nationally as a high quality service with excellent wait times and access rates. This service has received national recognition for its achievements:

- A recovery rate of more than 50%
- Wait time of 4 weeks (against a national target of 18 weeks)
- 95% patients reporting a positive experience

Our priorities for 2017/18 & 2018/19 are to ensure that current performance is maintained and that recovery rates are above 50%. This service will continue to evolve and we have secured National IAPT Expansion Site Funding from NHSE as wave 1 site to roll-out the IAPT service in managing long term conditions i.e. COPD/Diabetes.

Berkshire West is part of the University of Reading Children and Young People's IAPT collaborative and has been for a number of years. Many BHFT CAMHs Tier 3 staff and some local authority Tier 2 staff are undertaking CYP IAPT training. Learning from CYP IAPT has helped to shape care pathways and the development of an outcome framework in Berkshire West.

KPIs	2017/18	2018/19
Achieve a recovery rate of more than 50%	50%	53%
Waiting time of 4 weeks	75%	78%
95% patients reporting a positive experience	95%	98%

10.3 Early Intervention Psychosis (EIP)

Berkshire West Early Intervention in Psychosis service promotes early detection and engagement to reduce the duration of untreated psychosis to less than three months. BHFT employ specialist staff to provide a range of interventions, including psychosocial interventions and anti-psychotic medications, tailored to the needs of young people with a view to facilitating recovery. This service seeks to normalise experiences at a crucial developmental stage and offer therapeutic optimism, expertise and confidence in a recovery based approach. The service focuses on being person-centred, family focused, responsive and engaging.
In 2016/17 we have put in place a Service Development Plan with BHFT to implement a NICE compliant EIP service that is able to deliver the following recommended treatments to more than 50% of people within 14 days of referral:

- CBT for Psychosis (CBTP)
- Individual Placement Support (IPS) for education and employment
- Family Interventions
- Medicines management
- Comprehensive physical assessments
- Support with diet, physical activities and smoking cessation
- Carer-focused education and support programmes

This is being monitored monthly at our service and performance meeting with BHFT and we are working closely with the South Region EIP Support Team to develop an EIP service that will meet the national accreditation criteria in Berkshire.

In Berkshire we have set out some local outcome measures for the EIP service to deliver in 2017/18;

- Patient Reported Outcome Measures (PROMs)
- Patient Reported Experience Measures (PREMs)
- Carers Reported Outcome Measures (CROMs)
- Reduce Hospital Admission
- Improve Outcomes for BME Groups

10.4 Out of Area placements (OAP)

Berkshire patients should be treated in a location which helps them to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment. BHFT have experienced staff as part of their placement review team to regularly review all out of area placements and provide reports to a Berkshire West funding panel, plans are in place to repatriate patients into local services. The review officers have an important role in terms of care quality, service user experience and financial management. Commissioners will monitor the progress made in reducing OAPs and report to NHSE Quarterly based on BHFT submissions.

Berkshire West CCGs are also working with our local authority partners to develop the local provider market to manage complex needs mental health patients in the area ensuring they can remain connected to their communities.

10.5 Perinatal Mental Health

Berkshire West Perinatal Mental Health Service provides a comprehensive range of community services for women requiring pre-conceptual counselling Talking Therapy or who experience mental health problems or illness during pregnancy or in the first year after birth. The service provides assessment and management of women at risk of, or suffering from mental illness that requires pre-conception advice, is pregnant or in the post-natal period. The service supports mother and infant relationship in the context of maternal mental illness and offers a service that is fully integrated in existing mental health services in Berkshire.

The following will be delivered across 2017-2019:

- Central Point of Entry (CPE) will have an identified perinatal clinical lead who will undertake the majority of the clinical work relating to new referrals into the Trust and act as a resource for referrers and the CPE team in matters relating to perinatal assessment.

- CPE perinatal lead and Manager of Trust Perinatal Mental Health Services will provide guidance to professionals within the Trust providing perinatal care including joint visit where required.

- Care Pathway/CMHT teams will have an named perinatal lead who has sufficient identified and ring fenced time to fulfil the role in order to provide care to the majority of new referrals into their team from CPE and to ensure/enable quality liaison between relevant services. They will act as resource for information and support to colleagues who have a client already open within the team and who subsequently come within the perinatal remit.

- Females who are aged 16-18 at the time of pregnancy/referral/delivery will be assessed jointly between perinatal lead at CPE adult services and CAMHS and signposted to the most appropriate service.

- Women who may require need admission to MBU will be referred to CRHTT for intensive interventions at home but where care cannot be safely managed in the community with crisis team CRHTT and with regard to risk - admission to MBU is sought from 24 weeks of pregnancy and up to one year post-partum and will be directed to MBU where at all clinically possible.

- Admission to CRHTT will also be sought to facilitate discharge from MBU.

- The named professional for the service user will attend the reviews held at MBU prior to discharge to facilitate a support plan to enable discharge.

- Advice regarding medication during pregnancy or whilst breastfeeding to be provided by pharmacy or psychiatrist as required as part of a whole assessment.

- Referrals within four weeks of birth from any source to any team within BHFT are treated as 'urgent' to commence the assessment process on the same day regardless of the information provided in order to eliminate risk of psychosis (this is the point of highest risk of psychosis).

- Women who are pregnant and come into contact with BHFT services will have a maternity planning document completed to be shared between the woman and all professionals involved with the care of the woman during pregnancy and in the early post-natal period. This document will detail information about risk in respect of medication and risk of relapse together with a plan in the event of relapse.

10.6 Suicide Prevention

The Berkshire suicide prevention strategy is being developed and is out for stakeholder's consultation, it is expected that this will be agreed by key partners by 31st January 2017. The Berkshire suicide prevention strategy commits every organisation to reduce suicide rates by 25% by 2020/21. There is a clear action plan as part of the suicide prevention strategy supported by BHFT to reduce suicide rate amongst mental health service users. The plan will:

- Implement the NICE guidelines on self-harm, specifically ensuring that people who present to Emergency Departments following self-harm receive a psychosocial assessment.

- Evaluate the Berkshire CALMzone and recommission targeted suicide prevention work for younger men and middle aged men.

- Work to provide and commission interventions which improve the public's mental health. These may include: awareness of mental health and peer support in young people; anti-bullying campaigns in schools; addressing stigma and social isolation in older people; workplace health promotion and support with local business; working with police on mental health literacy; and addressing issues relevant to the local population.

- Ensure that local authority public health teams take the leadership for liaison with any Escalation Process in their area, and report on progress to the Steering Group.

- A named Highways England officer is identified to act as a liaison link and group member, and to share real-time intelligence of highways network incidents.

- Ensure that local authority public health teams work with other council departments such as parking and open space services to identify local actions to prevent suicide including staff awareness training.

10.7 Dementia

Identifying those living with Dementia and the provision of high-quality post diagnosis care is a high priority for the four Berkshire West CCGs.

We have an established nationally accredited Memory Clinic service provided locally by Berkshire Healthcare Trust. In addition we have commissioned an award winning service for young people with Dementia which plays a significant role in supporting younger clients and their carers. Following the refresh of our Berkshire West Dementia Stakeholders Steering Group in late 2016, we will, in conjunction with our partners and utilising the forthcoming NHS implementation guidance, conduct a gap analysis which will allow us to update our Prime Ministers Dementia Challenge for 2020 action plan.

Currently the average Dementia diagnosis rate across all Berkshire West CCG practices at Sept 2016 is 66.9%. However, two of our CCGs currently remain below the 67% target and with support from NHSE and the SCN they are implementing CCG specific action plans to improve diagnosis rates to 67% by March 2017 (Wokingham) & April 2017 (Newbury). However, it is recognised that with changes to the denominator in April 2017, our positon may deteriorate in some CCGs further against target but with a potential for improvement in Wokingham. (Worst case scenario is for the CCG average to fall to 64.1% with all four CCGs below the 67% target). Three of our four CCGs we anticipate will therefore be in a positon to reach the 67% target by 1st April 2017 and will continue to maintain this over 2017/18 and beyond. We will continue to work closely with Newbury & District CCG to improve their positon as quickly as possible through implementation of their comprehensive action plan. For all CCGs we will continue to commission regularly updated "Dementia lists" direct to all four CCG practices from our memory clinic provider, allowing data harmonisation and registers to be kept up to date. Across all four CCGs other initiatives will include further raising awareness, on the importance of recording Dementia diagnosis, mapping and improving referral routes into the Memory Clinic and focusing on ensuring accurate and timely coding of newly identified Dementia patients from several of our newly built local Care Homes.

Building on work underway in comparable and neighbouring CCGs, we will implement a new pathway in 2017 for Mild Cognitive Impairment, led by Newbury & District CCG. This will offer us the opportunity to monitor and appropriately identify deterioration which may lead to a further improvement in Dementia diagnosis recording. A mapping exercise to identify "Dementia Friendly Practices" during late 2016 will allow us to target and promote support and training to practices, with the aim of achieving 100% Dementia Friendly practice access to our population by March 2019. To become dementia friendly, GP surgeries will sign up to the local dementia action alliance and commit to carrying actions that aim to help people living with dementia and their carers. We are adopting the iSPACE model which consists of 6 key steps to becoming a Dementia Friendly Practice:

1. **Identify** one or two Dementia Champions in the practice
2. **Staff** who are skilled and have time to care
3. **Partnership** working with carers, family and friends
4. **Assessment** and early identification of dementia
5. **Care plans** which are person centred
6. **Environments** that are dementia friendly

In line with the aspirations of the Prime Ministers Dementia Challenge 2020 to have diagnosis and treatment of Dementia within 6 weeks of referral, we will continue the work already underway with our Memory Clinic to refine patient pathways. A key deliverable within our action plan will be the achievement of a dementia initial assessment within 6

weeks of GP referrals. This will require identification of variation in referral and diagnosis rates within primary care. We will provide dedicated support to those practices identified as outliers but also to allow us to share good practice between practices.

The integration of our Dementia Care Advisors within GP practices will further help support the identification of and provide improved ongoing support to dementia patients and their carers.

As well as building on the Prime Ministers challenge on Dementia in the 5 key areas of care, we will refocus on improving the quality of post-diagnosis treatment and support in line with the 2020 vision using benchmarking and best practice wherever possible.

Our current established dementia stakeholders group will meet monthly and will take responsibility for the implementation of the Dementia action plan for 2017/18 and beyond. This will include ensuring robust processes are in place to provide regular reviews of Dementia Care Plans, and this will align with our plans to extend care and support planning to other Long Term Conditions, including Dementia as well as our local enhanced service for anticipatory care planning. Recent data provided by the Department of Health's Dementia Atlas will be utilised to allow us to learn and share best practice wherever possible. By refining our models of Dementia care delivery, we will be looking at the option to further integrate older people's mental health specialists within our GP practice.

Outcome measures of importance to us will include admission avoidance, reduction in requirements for respite /social care intervention as well as reductions in the need for medical intervention (e.g. measure reduction in mental Health practitioner and community support worker contacts). This information is invaluable to assessing the value for money Dementia Services offer but also to release funds to allow further investment in Dementia services. By the end of 2017 we will have a clearer identification of the cost of current services and the size of any need for additional investment to meet the future needs of the population.

10.8 Emotional health and wellbeing in children and young people

We published our Local Transformation Plan for child and adolescent mental health and wellbeing in 2015 in response to Future In Mind and refreshed these plans in October 2016. Our Local Transformation Plans focus on integrating and building resources within the local community, so that emotional health and wellbeing support is offered at the earliest opportunity. This will reduce the number of children, young people and mothers requiring specialist intervention, a crisis response, an in-patient admission or out of area placement. Help will be offered as soon as issues become apparent.

As well as increasing the capacity of specialist CAMHs (Tier 3), Berkshire West CCGs have commissioned partners from the voluntary sector, third sector and Local Authorities to provide emotional and mental health services in the community before needs escalate to specialist level. We anticipate that access rates will be met through a combination of specialist (Tier 3) services and services from partners.

Additional specialist CAMHs staff have been recruited and trained and waiting times for specialist CAMHs have reduced. More children and young people are having treatment. In

17/18 waiting times will reduce further and expect there to be an increase in the number of children accessing help.

We are working to reduce CAMHs crisis mental health presentations through swifter risk assessment of new referrals and better risk mitigation of new and existing cases. Referrals are being triaged faster and urgent cases access help on the same day.

The CAMHs Urgent Care Pilot operates over extended hours Monday to Friday, over bank holidays and weekends providing timely mental health assessments and care. The service is integrated with RBFT to maximise joined up working and training opportunities. Short term intensive interventions in the community are provided to young people who have experienced a mental health crisis with the aim of reducing the number of children and young people who have a second crisis. The service also provides wrap around support when there are delays in sourcing a Tier 4 in CAMHS patient bed. In 16/17 the service will be evaluated and a sustainable model will be agreed and commissioned for implementation in 17/18. We are working with neighbouring CCGs and NHSE Specialised Commissioning to ensure best use of resources and implement a care pathway that reduces the need for out of area placements. The number of in-patient beds at Berkshire Adolescent Unit has been increased. The unit is now open 7 days a week.

Our CAMHS Community Eating Disorders service has been jointly commissioned with Berkshire East CCGs. The service became operational in 2016 and is on track to meet the access targets.

School based early identification and intervention projects have been commissioned. PPEPCare emotional health and wellbeing training is being delivered across the children's workforce including school nurses, GP's, school staff, Local Authority staff. An online Young SHaRON workforce support hub has been launched to support professionals who have concerns about children. School exclusion data has been analysed with partners to identify which young people are most likely to be excluded from school and where more help in schools might make a difference. This work will be carried forward into 17/18.

In 2016 we under took an Appreciative Inquiry into services for children and young people with autism, including those who are waiting for an assessment. We are using the learning from this inquiry to work with partners to develop improved care for these children across the system and across settings. Two voluntary sector organisations have been commissioned to provide support to families whose children are waiting for autism or ADHD assessment. We have also commissioned post diagnostic support to families whose children have a diagnosis of autism and other neurodevelopmental issues. The neurodevelopmental care pathway (ADHD and ASD) is being reviewed within BHFT.

11. Learning disability

11.1 Transforming Care

The Transforming Care Projecting Adult Needs and Service Information (PANSI) projections in 2015 identified 7313 people aged 18-64 with challenging behaviours in Berkshire West with projections showing a growth of 5% year on year until 2030. Predictions suggest nearly a third have an autistic spectrum disorder.

This Berkshire Transforming Care Partnership (TCP) builds upon the lessons' learnt from learning disability and autism schemes across Berkshire West and established partner forums focused on improving people's health outcomes, to ensure parity of access and equal opportunities for people with LD and/or Autism who have health and social care needs.

The TCP Board comprises 14 Health and Social Care partners across the county who hold a shared vision and commitment to support the implementation of the national service model for children, young people and adults with learning disabilities and/or autism, who have behaviour that challenges and may or may not have mental health issues and have come into contact with the criminal justice system. The model requires integration and collaboration by commissioners, providers and other sectors to enable this cohort of people to lead meaningful lives through tailored care plans that meet individual needs.

Berkshire Transforming Care Plan has 4 key aims:

1. Making sure less people are in hospitals by having better services in the community.
2. Making sure people do not stay in hospitals longer than they need to
3. Making sure people get good quality care and the right support in hospital and in the community
4. To avoid admissions to and support discharge from hospital, people will receive and be involved in a Care and Treatment Review (CTR)

To achieve those aims the TCP Board has established a programme and governance structure built around a number of work streams, with children and young people and those in transition being a core component of each.

11.1.1 Priority actions for 2017 – 2019:

We know that providing suitable accommodation and appropriate and flexible support in a home environment is key to helping people with LD and/or Autism come out of hospital and stay out of hospital; whether that be in an acute or secondary care setting. This will inform the development of a programme of work for 2017/18 and 2018/19 that enables the partners to have a coherent picture of demand and supply to underpin a strategic approach to market management to ensure that people with learning disabilities are able to access services in their community.

The new Berkshire TCP service model for people with learning disabilities and autism includes an Intensive Support Team (IST) who will provide high quality functional

assessment in the person's own home, aiming to improve safety for the person and reduce reliance on hospital admission. The service will use non-aversive strategies (Positive Behaviour Support) to improve people's lives and build resilience in a constructive way by focusing on improving quality of life and the reduction of behaviours that pose a risk to self and others.

The IST will be: safe, responsive, caring, effective and well-led with health and social care staff working closely together to improve people's lives, building resilience for the individual in their own environment and their community.

The TCP Board has set a plan to reduce Berkshire East and West CCGs commissioned in-patient beds to 10-15 beds per million population by the end of 2018/19. Working with the provider, Berkshire Heath Care NHS Foundation and NHS England Specialist Commissioning Team the plan is on track to reduce CCG and NHS England commissioned bed capacity from 44 to 28 within the time line. Working with the best of local experience, skills and knowledge a new service model has been created that incorporates Positive Behavioural Support and increased level of community based provision resulting in a reduction in beds. The Berkshire West CCGs and 3 local authorities are planning to deliver intensive care support in the community as a viable alternative to hospital assessment and treatment beds. This will be achieved through specialist skills and knowledge to be transferred to community support settings and for the remaining beds to be redesigned as part of a challenging behaviour pathway. Cost savings will be released for investment into community intensive support.

To ensure plans and changes maintain safe and high quality services, responsibility for the auditing of patient outcomes during the programme will sit with the TCP Star Chamber, a group of expert clinicians and service users.

The Primary Care work stream aims to produce a collaborative health action plan in 2016/17 that over the next 2 years will support people in health, education and community settings to identify their needs, their goals, outcomes and what they want to achieve for their own health and wellbeing.

National benchmarks of physical activity rates for children and young people with learning disabilities, and adults in residential care in relation to participation in sport are poor. The health action plans will aim to foster confidence in individuals and identify where support is needed to access a range of opportunities to improve physical health and reduce obesity rates.

The CCGs will work with BHFT to review the levels of mortality in Berkshire in line with the recommendations of the Mazars report. The CCGs will ensure that there is good quality healthcare to avoid unnecessary admissions, based on an understanding of the current rate and reasons for mortality amongst people with learning disabilities. In parallel the TCP board will identify how services will need to be commissioned and provided in the future to ensure that people with learning disabilities and/or autism with behaviours which challenge services are supported within their local community and only require in-patient services for clearly defined purposes.

A significant proportion of mortality rates are due to preventable illnesses or conditions (i.e. heart disease and diabetes). The action plans will improve information on good nutrition and improve access via advocates, to primary and secondary healthcare services e.g. Dental, GP, ophthalmic, occupational therapies and diagnostic services. In addition the action plans will address inequalities in the uptake of cancer screening by people with a learning disability across Berkshire West by targeting people most in need.

11.2 Special Educational Needs (SEND)

Berkshire West CCGs continue to work with local authorities, health providers, the voluntary sector, families and service users to improve collaborative working across education, health and care for children and young people with SEND aged 0 – 25 years and to give parents more control. This work is in accordance with Part 3 of the Children and Families Act 2014. A Designated Clinical Officer is in post to support to CCGs in meeting their statutory responsibilities for children and young people with SEND. “Local Offers” have been published in each area. The Local Offers provide accessible information on local services and resources for children with SEND and their families. The “Ready Steady Go” programme has been introduced in many clinical areas to improve transition into adult services and to better prepare young people and their families for adulthood. Education partners are considering how the Ready Steady Go principles can be aligned to Education Health and Care Plans to improve integrated working.

Community health services for children, young people and families (e.g. therapies, CAMHs) have integrated into a single team. The needs of children and young people referred to services are considered in a more holistic and collaborative manner with a greater emphasis on agreeing a joint care plan with meaningful outcomes with families.

12. Maternity

The CCGs Maternity Steering Group includes membership from all key partners including the MSLC and Thames Valley Maternity Network. The broad objectives of this forum are to:

1) Review the quality of maternity services provision for women across Berkshire West in line with the agreed service specification
2) To ensure that women’s feedback is heard and contributes to strategic planning
3) To agree key initiatives to improve the quality of maternity services for women across Berkshire West, in line with national guidance and recommendations and supported by all Berkshire West CCGs
4) To monitor the implementation and achievement of key initiatives and targeted service improvements in maternity care provision

It is collectively agreed by the forum, that the above overarching objectives will enhance the patient experience and support the choice agenda, in addition to the identification of any gaps in provision to ensure that any improvements in service provision are completed with the above as a priority.

When focussing on the various deliverables in order to achieve the objectives of the forum, in collaboration with the CCGs, RBFT have chosen to;

a) Prioritise the improvement of maternal choice through increasing the percentage of midwifery led deliveries (25% in 2017/18) and continue drive to recruit to midwifery vacancies until full establishment is achieved
b) Increasing the number of home births through commissioning of a dedicated home birth service commencing 1st April 2017, aiming to achieve 3% by Q4 2017/18
c) Reducing the need for RBFT to divert women in labour
d) Improved postnatal care through the introduction of smaller community teams (4-6 midwives) and a linked consultant obstetrician, it is thought that this will be fully implemented by March 2017.

It has been identified that in order to provide benchmarking with providers and visibility of performance trends, a Thames Valley Maternity Dashboard is currently under development. This is led by the network allowing for CCGs to monitor the providers against an agreed set of key indicators, it is hoped that this will be implemented by June 2017. The CCGs will utilise these indicators during the contract period 2017/19 to monitor performance and, where required, set improvement trajectories through the provider quality schedule within the NHS contract. Challenge, scrutiny and assurance of actions regarding these indicators will continue through the maternity steering group, reporting to the CMMV Programme Board.

The CCGs are also working with the Thames valley SCN to model the future demand for maternity services in the light of an anticipated rising birth rate as a result of significant housing growth within the locality.

In addition to the specific objectives highlighted above, within 2017/19, the CCGs will ensure progress is achieved to deliver the recommendations of the National Maternity Review, Better Births (Appendix 8).

13. Improving quality of care through better outcomes and experience

Ensuring the quality of patient care provided by our commissioned services continues to be a primary focus in 2017/19. Significant progress has already been made in addressing key quality priorities to date, including reducing patient harm, such as a significant reduction in grade three and four pressure damage, reducing incidents of infection and reducing falls causing serious harm. The monitoring of quality performance is underpinned by robust governance processes, which include benchmarking our providers' performance with other Trusts across Thames Valley and holding them to account using tools such as Quality visits, clinical audits, and improvement plans to ensure improvements are made when standards fail to meet contractually obligated expectations.

The contractual individual provider quality schedules set out the expectations for quality in 2017/19. The schedules are based upon year to date performance in 2016/17, triangulated with feedback from our patients/ users and GPs gathered and reviewed through our Quality Committee, findings from the regulator and local intelligence. The schedules are then amended to reflect local priorities with removal of indicators where consistent achievement has been noted or, the addition of new indicators based upon the collective guidance and feedback relating to services or processes.

The CCGs will continue to work with RBFT to monitor 104 day waits on the 62 day pathway with the expectation to move towards zero waits in this area in 2017/19. There is a clinical harm review process for all patients with a confirmed cancer diagnosis who have waited

longer than 104 days. The CCGs will continue monitor the outcome of these in 2017/19. In addition, the CCGs will continue to monitor cancer and RTT performance at the Royal Berkshire Hospital, ensuring progress to full compliance is sustained. All serious incidents (SI) will be monitored through our robust SI processes; ensuring learning from any lapses in care is effectively captured and embedded.

In 2017/19 the CCGs will continue to monitor progress being made by our providers following recent CQC inspections. A number of inspections were carried out during 16/17; this is inclusive of SCAS (all areas), Spire Dunedin, Circle Reading, Ramsay BIH and Maternity and Gynae at RBFT. The new CCG in-housed Quality Team will ensure action plans are established and monitored to address and note progress regarding any areas requiring improvement.

The CCGs will continue with its programme of Quality Observational visits to our providers across 2017/19, which are now inclusive of patient pathways, gaining direct feedback from staff, patients and their families on the care they are receiving. Recommendations from the visit are then shared with the Trust and followed up within the Clinical Quality Review group.

In 2017/19 the CCGs will continue to improve the quality of primary care provided across all of our practices and will take over the full quality improvement monitoring and supportive function in 2017/18. The CCGs have developed a quality scorecard for primary care to monitor performance and support continuous improvement in quality against key quality indicators, which will be monitored through the Quality Committee and at CCG Council Meetings to support improvement. The scorecard will form part of a broader Primary Care Quality Report which will also incorporate information on complaints, significant events, safeguarding incidents and other information relating to managing the quality of services provided. The CCGs will be developing a quality framework for primary care to set out clearly support and intervention to be taken when individual practices are not meeting the required standards expected by the CCG. The CCG primary care team, in partnership with the quality team will continue to support those practices in our area as rated by the CQC as requiring improvement, ensuring any decisions made are in line with our Primary Care Strategy and produce the best outcome for delivering the highest quality of care for our patients.

Part of this process will ensure there is a robust system in place for recording and monitoring any incidents which arise within the primary care setting. This process will also ensure that any learning that has arisen will be cascaded and embedded within the CCG constituent practices.

13.1 Avoidable deaths

The CCGs have a robust Serious Incident process with monthly meetings to scrutinise investigation reports into any incident which has resulted in serious harm or death of a patient. The CCGs will continue to ensure that any lessons learnt from these investigations are fully embedded within the organisation and will challenge robustly if there are any recurring themes, taking action as necessary if care falls below the quality standards we expect.

The CCGs will continue to encourage an open culture of reporting, which has seen a significant increase in reporting across all our providers in the past two years. Further scrutiny and assurance will also be sought in light of 'Mazars' recommendations, through the development of a Berkshire Wide mortality review of all deaths of patients with a learning disability, ensuring any learning is shared across all providers across the system, in partnership with Berkshire East CCGs.

13.2 Medicines Management

The CCGs recognise that medicines form a significant part in addressing quality of care in terms of better patient experience, improving health outcomes and reducing patient harm. Optimising the use of medicines aims to ensure that the right drug is received in the right dose in the right place; that the most cost effective choices are made in line with national and local guidance; and that only those medicines that continue to benefit a patient are continued.

Work streams carried out by the CCG Medicines Optimisation Team (MOT) to support these overarching aims include:

- A GP prescribing Quality scheme which has prescribing targets for practices to achieve.
- A prescribing support dietitian who reviews patients on gluten free foods, oral nutritional supplements and baby milks.
- A joint post with the Royal Berkshire foundation trust to ensure the most cost effective drugs are used across the interface

The schemes above are delivering successfully with over £770k of efficiency savings delivered up to September 2016

The CCG MOT is strengthening the relationship with secondary care by a number of initiatives.

- Developing a cellulitis pathway in order to manage more patients in primary care and reduce the number of won-elective admissions.
- Work with the secondary care dietetics department to stop Oral Nutritional Supplements being added to Electronic Discharge Letters for low risk patients, which then lead to these products being inappropriately continued into primary care

In 2017/18, the CCGs will continue to utilise the local health economy Antimicrobial stewardship (AMS) Network which will look at all aspects of AMS, including having a joint strategy that spans primary, secondary and community care.

13.3 Safeguarding

The CCGs will continue to be active members of three Local Safeguarding Children Boards (LSCB) and the Berkshire West Safeguarding Adult Partnership Board (SAPB) and will ensure our providers are fully engaged in delivering the safeguarding priorities of these boards. We will commit to improving safeguarding quality, by sustaining the improvement in compliance of delivering LAC Initial Health Assessments within 20 days and continuing to improve GP report submission to child protection case conferences.

All contracts and SLAs require providers to adhere to the Berkshire-wide safeguarding policies and procedures and to work within the framework of national guidance and legislation. Contracts also require all providers to complete an annual section 11 audit (adapted to include safeguarding adults), and to provide assurance of compliance of staff training levels, and continuing professional development covering topics such as their roles and responsibilities in regards to safeguarding children, adults at risk, Children Looked After, the Mental Capacity Act and Deprivation of Liberty Safeguards. Providers are required to inform commissioners of all incidents involving children and adults, including death or harm whilst in their care.

Our quality assurance reporting framework will monitor progress and contract compliance on the DH and Home Office Prevent strategy against NHS standard contract for all our providers. We will ensure quarterly reporting on training compliance and prevent referrals is submitted to our prevent lead. This training is in accordance with the NHS England prevent and training competencies Framework and as a CCG we have encouraged the use of both Home Office e-learning training and health wrap supported by the regional prevent co-ordinators forum. This is in accordance with the CCGs current status as a non-priority area.

13.5 Continuing Healthcare (CHC)

The Berkshire West CCGs are committed to ensuring their Continuing Healthcare processes are compliant with national guidance and delivered in a person centred way with the involvement of all key stakeholders.

To meet those aims Berkshire West have engaged with its local authority partners in a review of CHC processes, facilitated by the CHC Lead for NHS England South and the Lead for the CHC National Performance Advisory group. There are a number of agreed actions and these will be taken forward in 2016/2017 in an Action Plan with agreed timescales for implementation. This will improve the CCGs' processes for receiving referrals for CHC, undertaking multi-disciplinary assessments and supporting people who disagree with their assessment to appeal.

In addition the CCGs have signed up to the NHS England "CHAT" tool which enables CHC Services to evidence their compliance with the Quality Assurance Framework for CHC. We have completed the first upload of data in line with the timescales set by NHS England and plans are in place for the next phase.

14. Digital Transformation

14.1 The case for change

The Berkshire West Local Digital Roadmap forms part of the BOB STP digital work stream. The priorities described in the BOB STP are reliant on the development and utilisation of a number of technological innovations to enable improvement in outcomes, support of self-care and provision of a greater proportion of care in a community setting. The Berkshire West Local Digital Roadmap is aligned to the BOB Sustainability and Transformation Plan and includes a roadmap to achieve:

- Paper-free at the point of care.
- Digitally enabled self-care.

- Real-time data analytics at the point of care.
- Whole systems intelligence to support population health management and effective commissioning, clinical surveillance and research.

14.2 Digital technology as change enabler

It is recognised locally and nationally that the kinds of transformative change set out in the STP cannot be achieved without realising many of the opportunities afforded through extensive deployment of digital technology.

More recently the General Practice Forward View emphasises the importance of greater use of technology to connect primary care with others, for the sharing of best practice, for greater online access for patients and to deliver new modalities for provision of advice and support for patients and the public.

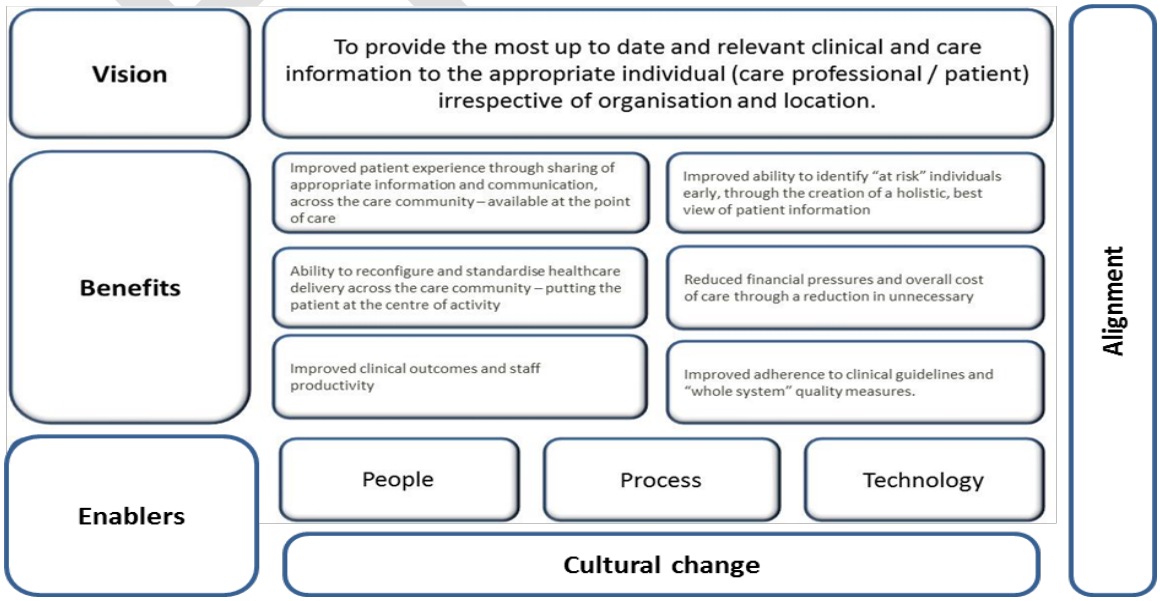
Initial benefits will relate to improvements in patient experience and patient outcomes, but with moves to more integrated care, further efficiencies will be realised by ensuring that patients can access the right care services to meet their needs, while clinicians can make better informed decisions and reduce duplication of tests and imaging.

14.3 Vision for digitally enabled transformation

Digitally enabled transformation is an essential component for addressing the challenges faced by the local health system. Berkshire West have been very clear that "digitally enabled transformation" should not focus on the technology alone but must be driven by the end-users, i.e. those at the front line of delivering care. Often the level of transformation of business processes is significantly under estimated.

Our vision is summarised in Figure 1 with investment in technology to support self-care through digital tools and enablers, data and information sharing across organisations and the development of a predictive urgent care model across the footprint.

Figure 1 - Berkshire West vision



The alignment of the local LDR into an integrated BOB STP LDR provides an aligned approach that has the commitment of provider, commissioner and local authority partners to realise the vision for health delivery for those we serve, and the ability to ensure that developments in digital maturity reflect the priorities of our future care models and services

The technology enablers of our digital vision need to meet a broad set of requirements across a number of care settings, however collectively, they need address three high level objectives:

- Improve the overall digital maturity of our providers
- Interoperability and information exchange between health and social care organisations
- Having a person / patient held record (PHR) for health and social care for the citizens
- Whole systems intelligence.

Engagement with both clinical staff and patients has been a cornerstone of our delivery approach to ensure that quality of care and patient experience are enhanced by our digital priorities.

Year one (June 2016 to June 2017) of Connected Care focusses on wide-spread deployment of the integrated digital care record platform (IDCR), making this accessible from Berkshire's main strategic health and social care systems. This will cover three phases, moving from 500 users in phase 1 to 3000 users by phase 3.

Based on the 10 universal capabilities and the work to improve digital maturity in providers, the Berkshire West Digital Transformation Board has agreed a set of work streams, which will be mirrored by work streams in the other economies of the STP. Work streams may cover a set of systems rather than a single deliverable – for example the record sharing work stream will not only deliver Connected Care, but will also deliver the federated architecture to support Primary Care at Scale, and e-Prescribing will look at delivering these systems in the acute sector, but also look at ePS incentives for dispensing practices. The work streams are supported by an STP wide professional reference group, information governance group and patient panel.

The focus on collaboration across the STP allows shared learning across the 3 health economies. Berkshire West intends to learn from work currently underway in Buckinghamshire on digital consultation, particularly in relation to urgent on the day Primary Care and remote services to Care Home residents. The Digital Centre of Excellence in Oxford University Hospitals will support improved digital maturity in our acute provider, and the pan Berkshire Work on personal health records and our healthy workforce pilot provide innovative approaches that can be shared.

We will monitor improvement in outcomes delivered through the clinical change programmes that Connected Care and our broader digital agenda enable. We intend to work with partners to develop a benefits model for enabling technology, which will help us to identify process benefits directly attributable to deploying technology but also quantify the extent of outcome improvement that could not have been achieved without our digital transformation programme.

14.4 E-referrals

The CCG is forecasting to meet the national targets in relation to e-referral utilisation and is working with providers and GP practices to support delivery of these trajectories. There are some risks associated with achievement of this indicator though, especially at 100%. There is an issue specifically for 2 week wait referrals for RBFT where we have a very good clinical triage process that is initiated on e-referrals by GPs. However these 2 week wait clinics do not count towards utilisation for the national definition even though the referrals are taking place on the e-referrals system. The CCGs are working to try and overcome this issue locally without altering the excellent clinical pathway.

There are also some technical issues with the metric which will mean 100% is very difficult to achieve, even if GPs make all referrals on the e-referrals system. This is mainly because the numerator and denominator come from different data sources nationally and therefore the numerator is not necessarily a subset of the denominator.

15. Appendix

1. Delivery of the Nine Must Dos
2. Accountable Care System - PIDS
3. Berkshire West CCGs – Operating Plans on a page
4. Berkshire West CCGs – Primary Care GPFV plan
5. Berkshire West CCGs – Cancer Framework
6. Berkshire West CCGs – A&E delivery plan
7. Berkshire West CCGs – Dementia plan on a page
8. Berkshire West CCGs – Better births implementation plan
9. Berkshire West CCGs – Local Digital Roadmap
10. Berkshire West CCGs – Communication and Engagement strategy

NHS Newbury and District Clinical Commissioning Group

NHS North and West Reading Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

2017/19 Plan on a Page

Ensuring high quality patient care is delivered by our commissioned services through the delivery of our Quality Improvement Strategy 2017-20, including:

- Implement 'Better Births' action plan
- Develop a quality framework for primary care
- Develop a strategy for antimicrobial stewardship that spans primary, secondary and community care

Work with partners in Berkshire West, Oxfordshire & Buckinghamshire to achieve a high quality sustainable NHS by preventing ill health, improving access to urgent care, hospital services, mental health and working with NHS England to improve specialist commissioning.

Transform mental health services in line with the Five Year Forward View and national standards, ensuring "parity of esteem" by improving access, providing early intervention and integrating services.

- Maintain performance of psychological therapies and expand into managing LTCs
- Review Out of Area Placements
- 50% of adults with 1st psychosis episode start treatment in 2 weeks
- 10% reduction in suicide rates
- Further reduction in CAMHs waiting times
- Commission new urgent care service for CAMHs following evaluation of pilot
- Improve collaborative working for people with Special Education Needs and Disabilities
- Achieve/maintain 67% dementia diagnosis

Achieve financial targets which are dependent on delivery of the QIPP programme.
Create efficiencies by working with our providers in new ways as an Accountable Care System.

Deliver the GP Forward View through our Primary Care Strategy, to ensure effective and sustainable general practice through new workforce models, estates, access and technology
Deliver a patient centred, integrated approach in primary and community settings for people with multiple long-term conditions through to end of life care.
Specific focus on Diabetes, through better use of technology and enhanced access to education and improved care for Diabetics with the most complex needs.

Implement Berkshire Transforming Care Plan which includes:

- Improving quality of care and ensuring community services for people with learning disabilities, including children, are available
- 75% of people with learning disabilities have access to NHS Health Check by 2020

The local cancer framework will deliver the strategic priorities outlined in "Achieving World-Class Cancer Outcomes: A Strategy for England" and work streams have been developed to:

- improve early diagnosis, increase screening rates and prevention, improve 1 year survival rate and access to recovery packages and enhanced end of life care
- Achieving and maintaining constitution waiting time standards of 62 days for cancer

Redesign pathways, and reduce clinical variation working with our providers in orthopaedics, musculoskeletal, ophthalmology and develop a new model of delivering out patients.

- Meet national targets by ensuring that no fewer than 92% of patients are seen within 18 weeks from referral
- 100% use of e-referral system by March 2018

Work with other health and social care organisations to:

- Deliver an agreed A&E improvement plan and achieve the 4 hour constitutional target
- Provide new integrated 24 hour urgent clinical assessment and treatment service bringing together NHS 111, GP out of hours and other clinical advice, such as dental, medicines and mental health
- Reduce Delayed Transfers of Care
- Reduce Non Elective Admissions for our most vulnerable patients of all ages
- Meet 7 day hospital service standards

2017/19 Plan On A Page

Local Plans

NHS Newbury and District Clinical Commissioning Group

NHS North and West Reading Clinical Commissioning Group

NHS South Reading Clinical Commissioning Group

NHS Wokingham Clinical Commissioning Group

Newbury & District CCG

- Promote healthy lifestyles in partnership with Public Health colleagues with a particular focus on:
  - Referring individuals into the National Diabetes Prevention Programme
  - Tackling childhood obesity
  - Falls prevention
  - Alcohol misuse
  - Targeting specific wards that have high levels of Non-elective admissions to hospital
  - Working together to do joint communication and engagement events.
- Establish integrated community teams which wrap around a GP practice population. Work with our providers and social care teams to streamline services so that patients get timely and co-ordinated care.
- Implement the Delayed Transfers of Care local action plan and work with the Local Authority through the Better Care Fund to increase capacity in the community by commissioning additional 'step down' beds.
- Continue to be system leaders working through the Health & Wellbeing Board and to deliver the two objectives identified for 2017-2018 which are alcohol harm reduction and building community resilience.
- Facilitate collaborative working between our GP member practices to create capacity in Primary Care. Integrate and build on the schemes piloted in 2016-2017 such as utilising Pharmacists in General Practice, providing enhanced medical administration training and expanding the comprehensive digital 'front door' to practices which aims to boost productivity by encouraging patients to do more online.
- Improve the uptake of diabetic patients who have received structured education. Increase the number of patients to 15%.

North & West Reading CCG

- Promote healthy lifestyles/services, particularly decreasing inactivity and smoking rates.
- Improve prevention of diabetes & care of pts. with diabetes by practices participating in NHS Diabetes Prevention Programme and reducing no. of diabetes pts. with HbA1c>75.
- Improve care of pts. with hypertension by continuing to increase no. of known hypertensives & increase % of patients with BP <150/90.
- 75% of high risk Atrial Fibrillation pts. to be on anticoagulation, reducing stroke emergency admissions .
- Increase breast screening rates to over 80%, maintain bowel cancer screening rates & non-attendance/completion flagged on clinical systems supporting opportunistic screening conversations.
- Support practices to become 'dementia friendly.'
- Increase CKD pts. treated with ACE-I or ARB
- Provide referral support by improved GP & Consultant engagement at point of referral.
- Support emotional resilience in children & young people through promotion of MindEd, School Link & Emotional Health Academy.
- Implement 'wellbeing' service for Reading people, supporting them to stay well by linking patients to sources of support in the community.
- Facilitate collaborative working between our GP member practices to create capacity in Primary Care.

South Reading CCG

- Work with Reading Borough Council to promote healthy lifestyles/services particularly decreasing inactivity and smoking rates.
- Continue to support the collaboration of GP practices through the South Reading Alliance and University practices cluster, to redesign the workforce, ensure sustainability and improve access.
- Participate in diabetes related prescribing targets to optimise medications to improve outcomes for diabetic patients.
- Improve outcomes for cancer patients by working in partnership with Macmillan and Rushmoor Healthy Living to raise awareness of the symptoms of cancer in the seldom heard population and introduce a 'Teachable Moment' programme to encourage lifestyle changes in people with negative cancer diagnoses.
- Increase number of known hypertensives to 14,288 by March 2018.
- Reduce rates of active Tuberculosis by promoting the New Entrant Screening Service and raising awareness of Tuberculosis with target populations.
- Implement 'wellbeing' service for Reading people, supporting them to stay well by linking patients to sources of support in the community.
- Review the alcohol pathway locally to increase screening opportunities and reduce acute presentations for alcohol related conditions.

Wokingham CCG

- Work with Wokingham Borough Council to promote healthy lifestyles/services.
- Implement Community Health and Social Care (CHASC) integrated model of care by September 2017.
- Support the development of collaborative working between Wokingham CCG practices with the development of an "alliance" by June 2017, to support workforce redesign improve access, and ensure sustainability.
- Increase the number of patients with diabetes (diagnosed for less than a year) who attended a structured education course (from 5.86% to 15%).
- Through CHASC, reduce non-elective admissions amongst the top 10% at risk patients by 7.5%.
- Increase referrals to Community Navigators by 25%. supporting people to stay well by linking them to sources of support in the community.
- Work with general practice and Wokingham Borough Council to ensure there is sufficient built capacity of primary care for the borough's growing population.